Childhood grief in the context of the HIV/AIDS epidemic in northern Namibia

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBS	Centraal Bureau voor de Statistiek, Statistics Netherlands
CONSEC	Constructing Human Security in a Globalizing World
CT-OVC	Cash Transfer to Orphans and Vulnerable Children
DAPP	Development Aid from People to People
DPM	Dual Process Model (*Dual Process Model of Coping with Loss)*
FAO	Food and Agriculture Organization
FCG	Foster Care Grant
GIPF	Government Institutions Pension Fund
HIV	Human Immunodeficiency Virus
ICG-RC	Inventory of Complicated Grief-Revised for Children
ID	Identification
IHME	Institute for Health Metric and Evaluation
LAC	Legal Assistance Centre
MGECW	Ministry of Gender Equality and Child Welfare
MHAI	Ministry of Home Affairs and Immigration
MoHSS	Ministry of Health and Social Services
MoLSW	Ministry of Labour and Social Welfare
NGO	Non-Governmental Organization
NHIES	Namibia Household Income Expenditure Survey
NPC	National Planning Commission
NSA	Namibia Statistics Agency
OAP	Old Age Pension
OVC	Orphans and Vulnerable Children
PEPFAR	US President's Emergency Plan for Aids Relief
PLWHA	People Living With HIV/AIDS
PSTT	Psychosocial Transition Theory
PTSD	Post-Traumatic Stress Disorder
SIAPAC	Social Impact of Assessment and Policy Analysis Corporation

SRCD	Society for Research in Child Development
SSA	Sub-Saharan Africa
TCE	Total Control of Epidemic
UN	United Nations
UNAIDS	Joint United Nations programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	U.S. Agency for International Development
VU	Vrije Universiteit Amsterdam
WACPU	Women And Children Police Unit
WCPS	Women and Children Protection Service

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1 INTRODUCTION

1.1 DEFINITION OF THE PROBLEM

The death of a parent is ranked as one of the most stressful events in the life of children and adolescents (Harrison and Harrison, 2001). In sub-Saharan Africa, many children experience the death of a parent before the age of 18. In this region, adult mortality is one of the highest in the world (World Health Organisation [WHO], n.d.), with the number of orphans on the African continent totalling 52 million in 2015 (United Nations Children's Fund [UNICEF], n.d.). Namibia is a typical example of this. North-central Namibia is especially affected: a fifth of all children under 18 have lost one or both of their parents[1] (NSA, 2014a). The HIV epidemic has contributed to this high number of orphans. In 2009, orphans formed 15%[2] of the general Namibian child population, with approximately 50% of them believed to be orphaned because of AIDS (Ministry of Health and Social Services [MoHSS], 2009). The arrival of antiretroviral therapy (ART) has reduced parental death. It is expected that the uptake of such treatments has averted the existence of millions of orphans in sub-Saharan Africa (Anema et al, 2011). Nevertheless, still many children grow up without parents and 'face an existence with the effects of orphanhood as a legacy of the AIDS epidemic' (Macedo, Sherr, Tomlinson, Skeen & Roberts, 2018).

Parental loss in childhood can have a strong emotional impact on children. The Namibian Lifeline/Childline, which runs a national children's helpline, reported that loss-related grief and sadness were amongst the most frequently reported psychological problems that children and adolescents sought help for (interview Shityuwete, Windhoek, 2013). A greater understanding of the ways African children respond to parental loss is likely to improve the

[1] These percentages count for the area where my research took place.

[2] It is estimated that there were 155.000 orphaned children aged 0-17 years in Namibia in 2008, which is 15% of the child population – with 69.000 of these believed to be orphaned because of AIDS. In 2017, the number of orphans due to AIDS dropped to 34.000 (Joint United Nations programme on HIV/AIDS [UNAIDS], n.d). Recent number of Orphans and Vulnerable Children (OVC) is estimated to be 250.000 (UNICEF, n.d.a). In contrast, in the Netherlands in 2011, 1% of the child population were single orphans, whereas 0,001% of the child population were double orphans (Centraal Bureau voor de Statistiek [CBS], n.d.).

effectiveness of targeted bereavement interventions (Thurman, Tylor, Luckett, Spyrelis & Nice, 2018). More generally, Howell, Barret-Becker, Burnside, Wamser-Nanney, Layne and Kaplow (2016) argue that the staggering worldwide statistics of parentally bereaved children 'suggests that understanding the stressful experiences linked to parental death, as well as the consequent needs of youth dealing with these adversities, is a significant public health issue' (p. 152-153).

However, to date little scientific attention has been devoted to childhood grief in African contexts. A decade ago, researchers noted a shortage of literature on African children's grief experiences within their own cultures (Bray, 2003; Foster, 2002). Researchers also argued that little is known about the bereavement experiences of children in low-income countries, including those with endemic HIV where loss is common (Sherr and Mueller, 2009; Van der Heijden and Swartz, 2010). Since then, a few studies studies have been published on this theme (Wood, Chase & Aggleton, 2006; Thurman et al, 2018; Macedo et al., 2018). However, this literature does not include accounts of Namibian children. There is a particular need to understand the social and cultural contexts of childhood grief in African settings. Van der Heijden et al. (2010) argue that these dynamics of childhood grief are fairly unexplored, as most research is derived from the fields of psychiatry and psychology, emphasising both pathology and trauma (p. 44-45). In order to understand childhood grief among Namibian children, it is thus essential to understand their bereavement experiences, as well as to contextualize these experiences of loss.

A need for understanding children's experiences of bereavement

Many recent bereavement studies on children are quantitative, questionnaire-based studies that concentrate on complicated grief reactions (e.g. Brown et al., 2008; McClatchey, Vonk, Lee & Bride, 2014; Melhem, Porta, Shamseddeen, Walker Payne & Brent, 2011; Melhem, Porta, Walker Payne & Brent, 2013). Such studies have also been conducted in African settings (Pfefferbaum et al., 2006). However, there is a lack of research exploring the bereavement experiences of young people that 'draws on narrative, biographical or ethnographic research methodology, or that applies a sociological or anthropological theoretical perspective' (Ribbens McCarthy, 2007, p. 291). Such information is needed as there appear to be some gaps in our theoretical understanding of childhood bereavement (Brewer and

Sparkes, 2011, p. 283). For instance, little is known about 'the meaning bereaved young people attach to their experiences and how this meaning is constructed through the stories they tell and the narrative resources that are available to them' (p. 284). It is also important to better understand the processes that take place in children's lives to identify factors that assist them in sense-making of, and living with their grief (*ibid*.). Such research also provides access 'to the multi-layered and complex nature of living with grief over time for those involved' (Brewer et al., 2011,, p. 290).

From a methodological perspective, a qualitative approach is valuable, as it is extremely difficult to ascertain large samples of recently bereaved children (Dowdney, 2000). Dowdney (2000) asserts that 'the adoption of a rigorous qualitative methodology, appropriate to the specific question being studied would provide an opportunity for much needed theoretical and conceptual development upon which subsequent empirical studies could be built' (p. 828).

As has been noted, from a bereavement care perspective, understanding children's grief experiences is important as well. Rolls and Payne (2007) indicate that health professionals mostly have access to models which are founded on information from caregivers, but lack models that are based on young people's own bereavement experiences. Valentine (2006) likewise proposes the development of new models that are primarily grounded in the experiences of grieving people. Based on their study among bereaved parents, Stevenson et al. (2017) argue that insights into the experiences of bereaved people can help service providers to 'operate from a deeper, more global understanding of parent's lived experiences of grief' and make services more effective (p. 661).

Furthermore, attention to children's own perceptions and experiences is in line with the anthropology of childhood, which is the basis of this dissertation. This field seeks to document children's perspectives on, and participation in, the social world. Parental loss often affects a child's social world strongly, therefore understanding children perceptions in relation to this loss is essential in a broader understanding of childhood grief.

A need for a contextualized understanding of childhood grief

There is a need to culturally contextualize childhood grief after the death of a loved one as expressions and experiences of loss are likely to be modified by

cultural norms and ways of dealing with loss. This is in conjunction with a need to contextualize the social and financial aspects as well. Ethnographic studies on grief in adults suggest that cultural contexts pattern grief expression (Brison, 1995; Hemer, 2010; Hollan, 1995; Wellenkamp, 1988; Wikan, 1988). Moreover, Gilles (2006) notes that deriving meaning of death and dying from both individual and cultural perspectives may lead to new insights into loss and bereavement (p. 106). Some studies have already provided a culturally informed picture of childhood grief. For instance, the study of Bordere and Larsen (2018) elaborated on 'oppressive contexts of loss and grief' among First Nations and African American youth in the United States (p. 136). Zhao et al. (2007) likewise contend that Chinese children face several cultural barriers in expressing grief, such as the beliefs that an excessive expression of grief is considered socially inappropriate, children do not have emotional problems and a sense that family issues are private. In general, however, few studies have examined the ways in which parentally bereaved children experience grief in diverse parts of the world.

This limited attention to contextualization appears to apply to the broader field of child development as well. LeVine (2007) argues that '…developmental psychology has consistently immunized itself not only to evidence from ethnography and cross-cultural replications that cast doubt on its theories du jour but even to the gross limitations of its empirical base for generalizing about childhood' (p. 250). He notes that most psychological studies of children were conducted in the United States and in other Western countries, whereas, according to the United Nations Population Division (2005, in LeVine, 2007, p. 250), in 2000, 88 % of primary school-aged children lived in less developed regions of the world. He further states that 'the resulting knowledge deficit has not been recognized by the child development research field' (p. 250). Only in the last two decades has the study of children in non-Western contexts contributed to resolving such a knowledge disparity (Evers, Notermans & Van Ommering, 2011, p. 2).

Yet the cultural contextualization of children's emotions has previously received attention, especially within the culture and personality movement that was at the core of American cultural anthropology in the first half of the 20th century. This movement related anthropology to psychiatry and psychology. It tended to perceive emotions as 'universal psychobiological processes underlying the expressive forms of collective culture' (White, 1997, p. 148). Founders were, amongst others, Margaret Mead and Ruth Benedict, students of Franz Boas. Mead

focused on the role of culture in child development and cultural transmission, while Benedict investigated the emotional patterns typical of particular cultures (LeVine, 1997). Members of the movement 'were suspicious of general theories of child and adolescent development and attempted to use ethnographic and behavioral data from diverse cultures to construct more accurate generalizations about human development' (p. 102). After 1950, the movement lost interest among scholars. There was criticism on the lack of consideration of individual variation within a culture, and some insights were viewed as unscientific (Quinn, 2005, p. 477-478). John and Beatrice Whiting additionally contributed to a contextualized understanding of child development by documenting children's behaviors in six cultures and placing these in their social and economic context (Parish, 1997). However, the cultural meaning of actions, especially what the children themselves thought and felt was not considered within this project (*ibid*.).

In the eighties, there was renewed interest in emotion within American anthropology, amongst others in response to a 'dominant cognitive view of humans as mechanical "information processers"' and due to a 'renewed concern with understanding sociocultural experience from the perspective of persons who live it' (Lutz and White, 1986, p. 405). The complexity of emotional experiences, which is, amongst other factors, caused by multiple perspectives on events, received attention. Lutz et al. note that 'death, for example, can at once represent danger, loss, and a violation of one's sense of what ought to happen' (p. 427). Furthermore, a shift took place from comparing whether an decontextualized emotional experience is the same/different across cultures into understanding how people make sense of life events (*ibid*., p. 428). The particular ways in which cultural meaning and social structure relate to emotional experiences should be explored further (*ibid*.). White (1997) likewise notes that anthropological approaches towards emotions recognize that basic emotions 'are always, in some measure, culturally constructed' (p. 148). Such approaches open up 'a wide field of investigation for comparative research on the emotions in their social, cultural and political contexts' (p. 149).

Purpose of the study: exploring children's grief experiences

Given this literature, the purpose of the current study was to explore the grief experiences of children and adolescents bereaved of one or both parents in

northern Namibia, and to examine cultural, social and financial contexts of bereavement in order to provide a more in-depth understanding of childhood grief as a psycho-biological *and* culturally and socially expressed phenomenon. This study is characterized by the fact that it took place in an area with a previously high AIDS mortality rate (UNAIDS, n.d.) and in a specific cultural setting, as it was conducted with Ovambo respondents. Four aspects of childhood grief are central to this thesis, these are dealt with in four sets of sub-questions.

1. The importance of gaining insight into the cultural and social contexts in which children experience parental loss has been emphasized in this introduction. The first set of sub-questions, dealt with in Chapter 3, is: (i) What are the cultural norms regarding childhood grief and ways of dealing with loss in northern Namibia?, and (ii) How is grief experienced by children and adolescents in this region and what are their ways of dealing with parental death?
2. Scholars emphasize the central role of communication within families in the grieving and bereavement process (Bosticco & Thomson, 2005, p. 273). Orphans in northern Namibia are mainly taken care of in the extended family (Social Impact of Assessment and Policy Analysis Corporation [SIAPAC], 2002). So how is parental loss discussed and dealt with in such a family setting? Furthermore, family communication in relation to AIDS-related death is often surrounded by silence and secrecy in a southern African setting (Wood et al., 2006). The second set of sub-questions, discussed in Chapter 4, is: (i) What information about the late parent is desired by children and adolescents and provided to them by caregivers? and (ii) In the case of 'silence', what are the reasons for this limited communication?
3. The financial consequences of the loss of a parent, partner or child has a subordinate role in the bereavement literature (Corden & Hirst, 2008, p. 209). However, parental loss in northern Namibia is likely to affect the economic security of children. Since 2002, Namibia has increasingly introduced child grants for orphans to tackle poverty among this group of children (National Planning Commission [NPC], 2010). The third set of sub-questions, addressed in Chapter 5, consists of: (i) How do the financial consequences of parental loss, as perceived by children, affect their experiences of loss and grief? And, (ii) How does the support of orphans (for example by the state) influence the economic security of orphans?

4. Orphans' social security may come under threat in their foster home situations. Studies on orphans living in extended families in sub-Sahara Africa suggest that they are vulnerable for several forms of maltreatment (Kidman and Palermo, 2016; Morantz et al., 2013). Chapter 6 discusses orphans' responses to bereavement in relation to such insecurities. The fourth set of sub-questions, which is dealt with in this chapter, pertains to: (i) How does maltreatment in the child's home situation affect their experiences of loss and grief? Various state actors deal with child protection in Namibia. The second sub-question relates to: (ii) How does the protection of orphans (for example by the state) influence the social security of orphans?

This chapter

This chapter lays out the theoretical orientation of this dissertation. It discusses the anthropology of childhood, and - as this thesis is built on approaches towards grief and bereavement from the disciplines of anthropology, sociology and psychology - it provides a brief overview of these theoretical perspectives as well. We will next discuss the local context of the study: briefly describing the HIV epidemic in Namibia and detailing relevant themes of the Ovambo context; the ethnic group to whom the research participants belonged. Lastly, this chapter provides an overview of the research area and details on the research participants.

1.2 THEORETICAL ORIENTATION

The theoretical orientation of this thesis is a problem-oriented approach in dialogue with the literature. Each chapter discusses a set of theories that relate to the subject of that particular chapter. Two main elements, however, form the basis of my theoretical approach. The anthropology of children and childhood is my theoretical orientation for researching children. In order to study grief among children I use anthropological, psychological and sociological approaches toward grief and bereavement. Hereby I do not intend to provide a general theory about childhood grief, but I aim to give insight into how these disciplines can complement each other.

1.2.1 Anthropology of children and childhood

The starting point of this dissertation is an anthropology of children and childhood. This is understood here as an anthropology in which 'children's own perceptions are at the centre of analysis, ethical considerations and methodology' (Evers et al., 2011, p. 3). Studying childhood grief from this perspective allows us to gain insight into themes that children bring up and consider important in relation to parental loss. In the discussion of my results, children's quotes are frequently used to make their own experiences and perceptions even clearer. However, this focus on children's experiences goes hand in hand with attention to the social, cultural and economic contexts of these children's lives and the adult perceptions. Such an approach towards the study of children is also recommended by Lancy (2012), who criticizes studies that primarily rely on child interviews, whereas 'a robust anthropology of childhood' must be based on a traditional, multi-method approach employed by fieldworkers (p. 4).

The interest within anthropology on children's perspectives can be traced back to Hardman (1973), but only through the work of the sociologists James and Prout (1990), did this approach gain attraction. Rapport and Overing (2000) argue that for a long time anthropological work on children has been diverse, without being coherent (p. 29). From the 1920s onwards anthropologists conducted ethnographic research on childhood among human populations across the world, applying different theoretical frameworks for analyzing their data (LeVine, 2007, p. 248). Rapport et al. (2000) note that the realization that 'children might be looked to for their own accounts of experience, of participation, activity and relationship in socio-cultural milieu and beyond' was something of a revolution in the anthropological study of childhood (p. 31). Thus, children's perceptions were recognized for their importance towards a broader understanding of social worlds. The work of James and Prout (1990) assumes the centrality of children as actors. In a revised edition of their earlier book, James and Prout (2015) argue that 'childhood and children's social relationships and cultures are worthy a study in their own right, and not just in respect to their social construction by adults. This means that children must be seen as actively involved in the construction of their own social lives, the lives around them and of the societies in which they live' (p. 4). From this perspective, children are no longer seen as passive receptacles of adult socialization, but as active in determining their own lives and the lives of

those around them (Heywood, 2018; Tisdall & Punch, 2012). James et al. (2015) argue that the idea of children as agents and actors in the social world, in combination with the idea of childhood as a permanent feature of social structure, and the notion of the historically and culturally specific constitution of childhood, provided a new lens to think about children and childhood which helped establish childhood studies as a distinct field of enquiry (p. viii).

A child is an agent but also part of a world of socio-cultural structures run by adults (Rapport & Overing, 2000, p. 32). Therefore, various authors have nuanced the possibility of children to exercise their agency. For instance, Boyden and Mann (2005) make note of children's constrained agency by stating that 'children are often the most affected by adverse circumstances because of their relative immaturity and their lack of social power' (p. 3). Cocks (2006) argues that essentialist notions of agency, including a lack of attention on the existence of dependencies and immaturity within agentic action, might have caused certain groups of children who live outside the main perception of childhood, such as disabled children, to be excluded from studies on childhood (p. 254). Lancy (2012) strongly critiques, as he calls it, 'the movement to promote children's agency as a cornerstone of research, care, education and intervention with children' (p. 1). This movement would be 'harmful to a scientific approach to the study of childhood, distorts or ignores key understandings of the evolutions of childhood and culture.....the agency movement is ethnocentric, classist and hegemonic representing the dominance of contemporary bourgeoisie child-rearing' (*ibid*.). Instead, for example as Bluebond-Langner and Korbin (2007) argue, the degree of children's agency should be studied in relation to their vulnerability. They note that children's statements should be accompanied by accounts of 'how what they say is played out with attention to the social and cultural constraints in operation at that time' (*ibid*., p. 243). In this way, justice can be done to both their experiences of powerlessness and resilience (Bluebond-Langner et al. 2007). This thesis does not explicitly focus on children's agentic action. Nevertheless, examples of children's own power to act in their worlds can be found in this thesis. For instance, Chapter 5 describes how some children ran away from their foster home in order to get away from an abusive situation, or informed a relative about the mistreatment.

Other authors criticise the anthropology of childhood for paying too little attention to the fact that childhood is a time of transition and change. For instance,

Heywood (2018) notes that childhood is not only a social construction, but indeed a transitional phase in life and there is a strong biological basis for child development. Montgomery (2009) notes that within the anthropology of childhood approach the notion that children are 'human becomings' is often rejected as children should be seen in their own terms and not as incomplete adults (p. 9). She however makes a case for seeing children both as human beings and human becomings by stating: 'children can be of interest for what they are now, yet children are also becoming something else, they change and transform from the socially immature to the mature. [....] there is no society that does not acknowledge that children (however they are defined) are very different from adults, have different needs, and have different roles and expectations places on them' (*ibid*.). In this thesis, both children and adolescents participated, which gave insight into how parental loss is perceived and experienced during various phases of childhood. Furthermore, the longitudinal approach of this study offered the ability to examine processes of transition and change. For instance, Chapter 4 shows that children's and adolescents' preferences for communication about parental loss are not fixed notions but often change as they grow older.

Relational processes

In this study, children within families are the focus of attention. Most orphans in northern Namibia live in a family context; with their surviving parent, in extended family settings, or in the households of unrelated acquaintances. Concern with relationality, especially intergenerational relationships, is one of current themes within childhood studies (James et al., 2015, p. x). For instance, Bluebond-Langner et al. (2007) note that the different worlds children live in must be simultaneously visible in the study of children, including worlds in concert with others (e.g families and neighbourhoods) (p. 245). Intergenerational relations, Mayall (2014) argues, should be viewed as processes, because children as well as the adults in their lives keep on growing older and go through life phases (p. 350). Interdependence and mutual responsibility throughout the generations, including children's contribution to this process, are important to take into account (*ibid*). Uprichard (2010) states that 'it is precisely by focusing on the relational processes that the generational perspective assumes that children are necessarily involved in

constructing childhood, which itself is in turn also relationally constructed through other structural categories (e.g. 'adulthood', 'parenthood' etc.) (p. 4, 5).

Children' experiences are often formed through such relational processes. Every child is embedded within a network of social and economic relationships, and these relationships, especially family relations, have a strong impact on children's experiences (Crivello, Camfield and Woodhead, 2009). Crivello et al. write: 'children learn and negotiate deep-seated assumptions and values, expectations, habits and orientations, especially through their day to day interactions with parents and other family' (p. 55). Individual approaches in studying children may thus fail to understand these complex interactions. Evers, Vadeboncoeur and Weber (2015) state: 'setting children apart as individualized entities, as opposed to situating them in relationship to family and community, does not do justice to their roles in broader social settings. Rather, it might help to see the interlacing of socio-cultural network and individual experience' (p. 54-55).

In the bereavement literature, such interlacing is stressed as well. Stroebe, Hanson and Stroebe (1993) note that individual reactions to bereavement are strongly molded by those of the family; it is therefore important to understand the family context in which grief takes place. Tremblay and Israel (1998) likewise state that including both parent and child perspectives provides a comprehensive picture of childhood grief (p. 435). In my study, relational processes within families, and the position of a child within its household have been considered. For instance, Chapter 4 explores caregiver-child communication on parental loss. The combined information from both children and adolescents, and their caregivers or remaining parents was essential in reaching a more complete understanding of childhood grief in the northern Namibian setting.

1.2.2 Theoretical perspectives on grief

In this thesis, different theoretical approaches towards grief and bereavement have been applied. As Stroebe, Stroebe and Hanson (1993) argued more than two decades ago, which is still relevant today: 'there is no broadly applicable, integrative theory of bereavement' (p. 7). Instead the experience of bereavement has been theorized across a variety of disciplines. In order to gain insight into the disciplinary frameworks of the approaches used in this dissertation, this section

briefly discusses some theoretical perspectives on grief within three disciplines of the social sciences, namely psychology, anthropology and sociology.

Definitions of grief

First of all, it is useful to look at the ways grief is defined. Hereby three terms are distinguished: grief, mourning and bereavement. *Bereavement* refers to 'status with respect to loss, regardless of subjective experience' (Melhem et al., 2011), thus the 'objective situation of having lost something or someone significant' (Jakoby, 2012, p. 680). *Grief* is defined by Stroebe and Schut (1998) as 'the primarily emotional reaction to the loss of a loved one through death, which incorporates diverse psychological and physical symptoms and is sometimes associated with detrimental health consequences' (p. 7). However, grief is also more broadly defined as 'the emotional response to loss' (Jakoby, 2012, p. 681) or as the 'subjective experience of loss' (Melhem et al., 2011). *Mourning* is 'the social expression or acts expressive of grief, which are shaped by the practices of a given society or cultural group (e.g. mourning rituals)' (Stroebe et al., 1998, p. 7). As Lofland (1985) notes, grief thus refers to what is felt, whereas mourning refers to what is done (p. 173). However, a strict division between the constructs of grief and mourning might not be accurate. For instance, Hockey (2001) points to the interrelation between the two constructs as mourning practices can shape the emotional experience of grief and vice-versa (p. 187). Gross (2018) likewise notes that the moment grief is expressed, it becomes mourning, which indicates that both processes are interlinked and experienced within a cultural framework (p. 63). Furthermore, Klass (2002) states that in the distinction between grief and mourning, with a focus on feelings or action, thought or the cognitive meaning of loss is largely absent.

Psychology

Valentine (2006) notes that 'the psychologizing of grief that has characterized twentieth century academic constructions of bereavement has had an immense impact on understanding and practice' (p. 73). Within the discipline of psychology, two important general types of theory on grief emerged (Stroebe et al., 1993, p. 7). Firstly, depression models of grief, which analyze grief as an emotional reaction and focus on understanding the emotional symptomatology in

response to grief, emerged from the psychoanalytic tradition with Freud's ideas being the most influential (*ibid.*). Freud emphasized the importance of severing the emotional ties to the deceased and focusing on new relationships; this emotional separation from the loved one is achieved through 'grief work' (Gross, 2018, p. 8). Secondly, stress models of grief that perceive bereavement as a stressful life event try to explain the physical health consequences of bereavement (Stroebe et al., 1993). At the same time, as Valentine (2006) notes, theories about the stages of grief were developed on the basis of original theories such as Bowlby's attachment theory (1980) and Kübler-Ross' stages of dying (1970). Henceforth mourning is viewed as an active process, comprising of tasks (Gross, 2018). For instance, Worden's tasks of mourning include tasks such as acknowledging and accepting the reality of death; processing the pain of grief; adjusting to a world without the deceased; and establishing an enduring connection with the deceased (Worden, 1996). Valentine (2006) argues that such 'prescriptions of grief' were especially adopted in bereavement counseling (p. 60). The stages approach towards grief have been criticized for giving a description of what normally happens - which would not do justice to other expressions or aspects of grief (Walter, 1994 in Sagberg & Røen, 2011). Other approaches towards grief include the Psychosocial Transition Theory (PSTT), whereby grief is seen as an adaptation to change (Parkes, 2010). PSTT explains the psychological change that takes place whenever people are faced with the need to undertake a major revision of their assumptions about the world (*ibid.*).

An important focus within psychology is the question as to whether grief becomes complicated or 'abnormal'. Gross (2018) states that the mental health community did not officially recognize any grief patterns as pathological before 2013, as bereavement was seen as a life problem which in some cases needs to be treated clinically (p. 89). However, much evidence has accumulated that supports the diagnosis 'complicated grief' (the disruption of a normal grief journey) or 'prolonged grief disorder' (a chronic state of intense grieving that disturbs functioning over months or years) (*ibid.*). Nevertheless, scholars caution against being too diagnostic regarding natural distress that comes with loss (Schuurman, 2017 in Arnold, 2018, p. 3). Futhermore, these approaches have been criticized for 'medicalizing and pathologizing' grief (Valentine, 2006, p. 61; Van der Heijden et al., 2010; Hemer, 2010; Jakoby, 2012). For instance, Valentine (2006) argues that interpersonal aspects of grief receive little attention in such approaches: 'grief has

been medicalized by means of such terms as morbid, unresolved, abnormal, complicated, chronic, prolonged, and the like. This places the focus on the individual's internal world rather than the social environment' (p. 61).

However, a 'resocializing' of grief has taken place within the discipline (p. 62). For instance, a growing awareness of the 'continuing bonds' that people maintain with their dead (see Klass, Silverman, & Nickman, 1996) has developed across the disciplines (Valentine, 2006, p. 62). By exploring continuing bonds, discursive and narrative approaches are often used, which 'revealed grief as profoundly social and highly varied' (Valentine, 2006, p. 62). In contrast to Freud, who argued that the deceased loved one must be completely given up, continuing bonds emphasize attachment after death (Gross, 2018, p. 43). Within this approach, grief reactions such as searching, yearning and sometimes expressing anger towards the lost attachment figure – which are often viewed within the psychoanalytical orientation as pathological – are considered aspects of normal functioning of the attachment system (p. 45). Continuing bonds can be either secure or insecure, for instance thinking positively about a deceased loved one versus being haunted by an (imagined) appearance of the deceased (p. 46). Continuing bonds as an approach towards grief is addressed in Chapter 3; in relation to participants' perceptions on connections between the living and the dead; in children's dreams about their deceased parents; and in the ways children remember their parents, such as by looking at their pictures.

Within the discipline of psychology, a further focal point is how individuals cope with or adjust to grief and loss. An important model for adjustment to loss is the *dual process model* (DPM) of coping with bereavement (Stroebe et al., 1998) – this model is described in chapter 3. The DPM is based on the idea that individuals have to cope with both loss-oriented aspects and restoration-orientated aspects, but that this process varies within individuals and cultures (*ibid*.). Although this model allows for cultural difference, it has also been criticized for being based on core features that focus on 'healthy grieving', which might be an inadequate perspective in relation to the diversity of experiences of bereavement (Currer, 2001, p. 54-55 in Valentine, 2006, p. 62). Chapters 3 and 4 explore how ways of dealing with loss in northern Namibia relate to the DPM. Children's adjustment to loss is an important theme in studies on parentally bereaved children (see Tremblay and Israel, 1998). Chapter 5 describes the importance of a safe physical and emotional environment in order for children to

adjust to parental loss and relates this to the experiences of the orphans in this study.

Anthropology

Anthropological work on bereavement has drawn attention to the 'cultural and social construction' of bereavement. This work has demonstrated the diversity of ritualistic behaviour around the world (Valentine, 2006, p. 62). However, Valentine argues that anthropological observations generally failed 'to penetrate the prevailing therapeutic discourse' (*ibid.*). In a way, a conceptual split existed between ethnographic studies of 'outer, observable behaviour' and psychological studies of 'internal worlds' (Hockey, 2001). Noret (2012) notes that although death has been a central theme within anthropology, the emotional experience of grief has not been investigated in detail (p. 273). Metcalf and Huntington (1991) likewise argue that the emotional impact of death has received little attention within the discipline as the interpretation of death related emotions across cultures is complicated; similar responses in different cultures might not correspond to the same underlying sentiments (p. 43-44). In anthropological work examining grief, the question of how cultures mediate the experiences and expression of grief as a response to the death of a loved one often stands central (see Chapter 3 for an overview of such work). The way grief is shaped by cultural factors has not only received attention within anthropology, but also across the disciplines, for instance within family systems theory (see the work by Rosenblatt (2013) in Chapter 4). Chapter 3 deals with themes concerning grief which are studied within anthropology and that are important for understanding grief among children in northern Namibia, such as: the duration, manifestations and health consequences of grief, connections between the living and the death, and the role of memory and forgetting the dead. Other approaches towards grief within the discipline consider the impact of the social-economic consequences of the death of a loved one; these are described in Chapter 5 and 6.

Sociology

Valentine (2006) notes that in the past, the topics of death and bereavement received relatively little attention within the discipline of sociology, but with important exceptions such as Durkheim's pioneering work on suicide (1952).

However, more recently, sociology has contributed to the 'resocializing of grief as a result of an increased focus on meaning-making, agency, diversity, discourse, narrative, reflexivity and intersubjectivity' (Valentine, 2006, p. 58). For instance, studies on the 'diversity' of bereavement, such as the unacknowledged grief of male partners of gay men who died in the early years of the AIDS epidemic (Wright & Coyle, 1996) are based on Doka's concept of 'disenfranchised grief' (Doka, 1999). These themes are given attention in this thesis as well; meaning-making (Klass, 1999) is an important theme in Chapters 5 and 6 of this thesis, loss as a disruption of a narrative identity (Neimeyer, 1999; Baddeley & Singer, 2010) in discussed in Chapter 4, and disenfranchised grief as a way to view children's grief is explored in Chapter 3. Valentine (2006) further notes that within sociology, 'the use of discursive approaches has facilitated the deconstruction of taken-for-granted categories and boundaries: between life and death, grief and mourning, and self and other' (p. 74). Qualitative approaches towards the study of grief have additionally highlighted the importance of reflexivity and recognition of ethical issues (p. 71); Chapter 2 discusses such methodological and ethical issues in-depth.

Jakoby (2012) argues that by approaching grief from a sociological perspective, it would be good to view grief as a social emotion (p. 679). Grief is hereby perceived as a normal emotional response to the loss of a significant other, whereby the feelings and expressions of grief vary according to social and cultural conditions (p. 680). Jakoby (2012) explores grief as a social emotion by using standard sociological theories of emotions, such as symbolic interactionism and structural theory. Within *symbolic interactionism* grief may be viewed as a 'painful rebuilding of the self' (p. 685). Ideas highlighted within this perspective are that a significant loss may be seen as a loss of self, as the self is constructed and defined in interaction with others (see Mead in Jakoby, p. 686). Furthermore, lost relationships between the bereaved and the deceased, bonds between the survivor and the deceased, and the issue of meaning of the deceased for the bereaved are all considered within this perspective. Moreover, the meaning of personal reminders for the survivors, such as photographs and personal possessions of the deceased, is emphasized within symbolic interactionism (Jakoby, 2012, p. 686-689) (see Chapter 3). Within *structural theory*, grief is related to social structure (Jakoby, 2012). Social structures may not only constrain the feeling of grief, but the death of a significant other may also represent a loss of status, especially regarding love

and support (p. 695-699). The ways social structures influence grief is discussed in Chapter 3 (the constraining of grief) and Chapter 5 and 6 (grief in relation to a loss of support).

In the current study, I have drawn from these three disciplines using a combined approach to study childhood grief. These disciplines contribute useful approaches that look at grief as a social and cultural phenomenon; thus emphasising that grief takes place as part of a particular social and cultural context. Hereby it is important to indicate how culture is seen in this thesis. Understanding what cultural processes might entail, it helps to identify what they are not. Ingold (2002) argues: '….what we do *not* find are neatly bounded and mutually exclusive bodies of thought and custom, perfectly shared by all who subscribe to them, and in which their lives and works are fully encapsulated' (p.330). Instead, Ingold notes that 'it might be more realistic, then, to say that people *live culturally* rather than they *live in cultures*' (*ibid*.). Thus, culture influences how people might interpret situations, including parental death. It is never only formed locally. The local is always - and even more so by globalization than in the past - influenced by higher-level and global processes, and these processes, in turn, cannot be understood without knowledge about the local (Eriksen, 2018). Therefore, culture is defined here as a 'shared and transmitted repertoire of meaning (values and representations) and related behavioural routines within human groups, constructed in social interaction' (J. Abbink, personal communication); these are dynamic and subject to constant change. Which repertoires of meaning are used, depends on the context and on the person that finds herself or himself in that particular situation.

1.3 LOCAL CONTEXT

1.3.1 The HIV epidemic in Namibia

HIV remains a leading cause of adult morbidity and mortality in Namibia, and the country still has one of the highest HIV prevalence rates in the world (UNAIDS, 2014 in MoHSS, 2016). The prevalence of HIV among adults aged 15-64 years in Namibia was 12.6% in 2017 (MoHSS, 2018). The Namibia Demographic and Health Survey of 2013 estimated that the national HIV prevalence rate varied

depending on sex, age, geography, and socio-economic status (Namibia Statistics Agency [NSA], 2014). For instance, HIV prevalence is higher among women compared to men, peaks in the 35-39 year age group, and is slightly lower in urban areas than in rural areas (*ibid.*). Northern Namibia is one of the areas especially affected by the HIV epidemic. Sentinel surveys[3] in the region where the research took place showed a HIV prevalence of 25,4% (MoHSS, 2016)[4]. The main modes of HIV transmission in Namibia are heterosexual sex and mother-to-child transmission (U.S. Agency for International Development [USAID] Namibia, 2009). There seems to be a number of issues that drive the epidemic, such as multiple concurrent partnerships, intergenerational sex, alcohol abuse (leading to risk taking behaviour), low levels of HIV risk perception, transactional sex and high levels of population mobility (*ibid*.). Furthermore, Fox (2002) argues that among many Ovambos the aversion against a public discussion of sexual matters, as well as minimal openness within the family setting on sexual matters, most likely contribute to the spread of the disease. For instance, in Fox's study (2002), many respondents disapproved of discussing sexual matters with children.

The epidemic led to a peak of AIDS deaths in the early 2000s. Figure 1-1 shows that in 2004 about 10.000 people died of AIDS in Namibia (UNAIDS, n.d.). During this time, the life expectancy at birth dropped from 58 years in 1990 to 49 years in 2004 for men and from 65 years in 1990 to 54 years in 2004 for women (Institute for Health Metric and Evaluation [IHME], n.d.) In my study, many parents of the orphaned children and adolescents who participated had died in this period; thus, it might be likely that a part of these deaths were AIDS-related.

Global trends in the AIDS epidemic are also reflected in Namibia. These trends show that the number of AIDS-related deaths is the lowest since early this century, and that an enormous scale-up in access to antiretroviral therapy has taken place (UNAIDS, 2018, p. 2). Although Namibia had one of the highest HIV-prevalence rates in the world, in the past 15 years the number of new HIV infections has halved (see Carelse, 2018). As Figure 1-2 shows, overall, the epidemic in Namibia appears to stabilize with a slow but sustained decrease in

[3] National HIV sentinel surveys are used to determine the HIV prevalence among pregnant women attending public clinics which offer antenatal care in Namibia, and offer data to estimate the HIV prevalence in the general population (MoHSS, 2016).

[4] These HIV prevalence rates are taken from a nearby town in the larger research area, which is representative measure point to the research village. The most recent sentinel survey in the area dates from 2016.

HIV prevalence among pregnant women since 2002 (MoHSS, 2016, p. II). The estimated number of new HIV infections in 2017 is less than 1000 (UNAIDS, n.d.). Furthermore, due to a high coverage (more than 95%) of pregnant women who receive ART, mother-to-child transmission of HIV has strongly decreased in Namibia.

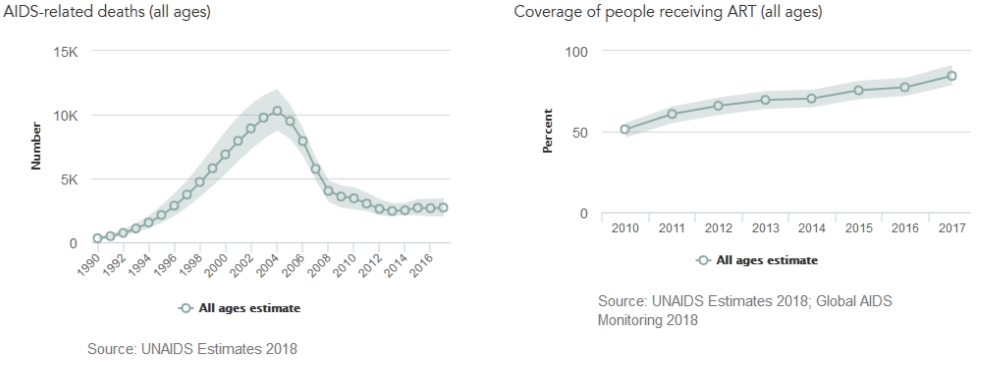

Figure 1-1: AIDS related deaths and coverage of people receiving ART (UNAIDS, n.d.)

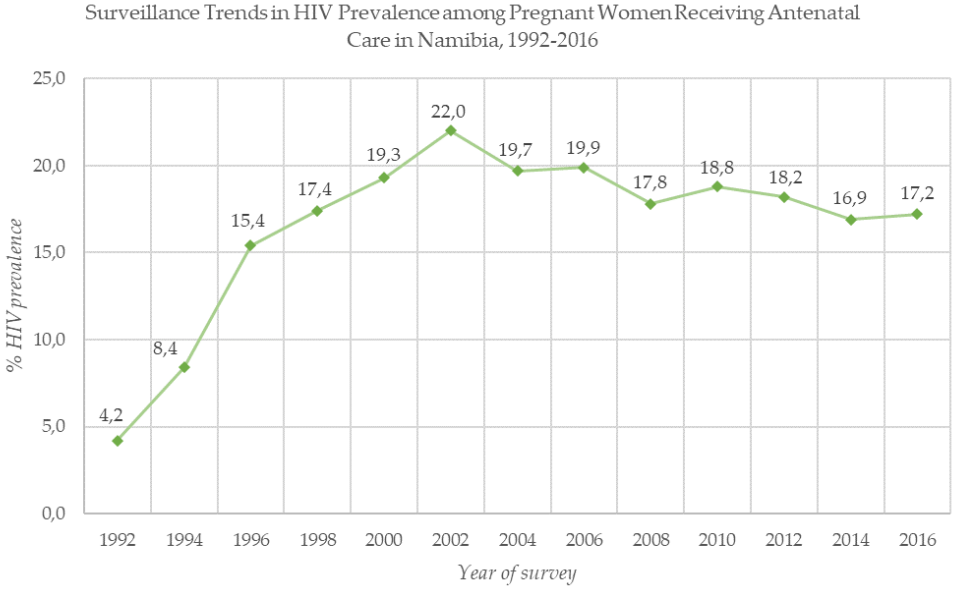

Figure 1-2: Surveillance Trends in HIV Prevalence among Pregnant Women Receiving Antenatal Care in Namibia, 1992-2016 (MoHSS, 2016)

A community-centered approach has been successful and has helped Namibia exceed some of the targets set by UNAIDS in 2014, according to the US President's Emergency Plan for Aids Relief (PEPFAR) (see Carelse, 2018). 86% of the people who are thought to be HIV-positive, know their status, 96% of the people who know their status are taking ART and 91% of the people who are taking the drugs have an undetectable level of HIV (see Carelse, 2018). However, UNAIDS (2017) estimated the coverage of people receiving ART was 84 % in 2017 (see also Figure 1-1 which shows the increase in the coverage of people taking ART in Namibia since 2010). A national NGO, Development Aid from People to People (DAPP), has run the programme Total Control of Epidemic (TCE)[5] since 2005, supported by PEPFAR and the Ministry of Health and Social Services of Namibia (Carelse, 2018; TCE, n.d.). In this programme, which covers the capital and the northern and central parts of Namibia, more than 200 fieldworkers test people at home with rapid HIV-tests, counsel them, and if needed, refer them to the nearest health facility (*ibid.*). Over 200,000 were tested for HIV, and they tried to trace the sexual partners of those infected with HIV. HIV-positive clients are visited and support groups are established to help people deal with the diagnosis and take the drugs, and when required to take turns collecting medication from the clinics which are sometimes far away (*ibid.*).

However, prevention measures in Namibia appear to be not adequate enough; the rate of new HIV infections is not falling fast enough (UNAIDS, 2018). According to the NPC (2010), the main challenges were the shortfall in budgetary resources, low rates of people knowing their status, gaps in human rights and social protection, associated risks of key vulnerable groups, and poor rates in the change of behaviour (p. 28). The high infection rate among women aged 15-24 continues to be a worry (MoHSS, 2016, p. II; Carelse, 2018).

Globally, children with HIV are left behind (UNAIDS, 2018, p. 2). UNAIDS notes: 'while the overall HIV treatment level is high, there is a huge injustice being committed against our children – only half of under-15s living with HIV were being treated last year' (*ibid.*). In Namibia, these rates are higher: of the 12,000 children between the ages 0-14 living with AIDS in 2017, 76% were receiving ART (UNAIDS, n.d.). My study shows that ART adherence is one of the problems that HIV-positive children are facing in northern Namibia (interview

[5] www.TCE-aids.org

doctor of local hospital, June 2013, Oshakati). For instance, many of these children were not assisted in their adherence by someone in their household, they were not accompanied by an adult caregiver to the health clinic or hospital for their check-ups, or they were not informed by their caregivers about their HIV infection and instead were told they suffered from another disease (*ibid.*). One of the child participants in my study faced such challenges, as discussed in Chapter 2.

1.3.2 The Ovambo context

North-central Namibia is predominantly populated by the Ovambo, an ethnic group that settled in this region around the sixteenth or seventeenth century (Mendelsohn, el Obeid & Roberts, 2000). About 50% of the population of Namibia belong to the Ovambo. Eight ethnic subgroups form the Ovambo, including Ndonga, to which most of this study's participants belonged. 'Oshiwambo' is the collective name of similar languages or dialects that is spoken by these groups (Malan, 1980). Although people refer to themselves as Ovambo this must, of coure, not be considered in essentialising terms.

Historical, political and economic background

The Ovambo seem to have lived relatively isolated for a long time, with little external influence. For instance, Stokes (2009) notes: 'in contrast to most ethnic groups in Africa, the isolated, low density pastoral nomadic lifestyle left the Ovambo people largely unaffected by the Swahili-Arab and European traders before the 19th century. When Germany established a colony in Namibia in 1884, they left the Ovambo people undisturbed' (p. 530). Only in the late 19th century, did the first missionaries settle (Malan, 1980). After 1915, the Ovambos also migrated to central and southern Namibia due to a flood of Ovambo refugees from Angola, a devastating famine, and trade that had come to a standstill because of the First World War (Gewald, 2003). Gewald notes: 'the Ovambo famine not only killed people […] the 'famine that swept' destroyed the autonomy of the Ovamboland kingdoms and allowed for the establishment of a South African colonial presence in the area' (p. 239). During the apartheid area, Ovambo people who were living outside the boundaries of the newly created

'Ovamboland' were relocated, and needed a work permit to leave (Brown, 2011, p. 161). In 1990 Namibia gained independence from South Africa.

The old political system resembled a feudal society (Hiltunen, 1993, p. 15). The king had counsellors who ruled their own districts; these were again divided into smaller districts, which were ruled by headman (*ibid.*). Parts of this system are still in place. For instance, the administration of communal land is typically allocated by traditional leaders and chiefs, kings and headmen (Behr, Haer & Kromrey, 2015). In this thesis, the role of the headman in conflicts over children's care or child abuse is briefly described.

In the past, the Ovambo economy was mostly based on agriculture and cattle raising, whereby the family was the basic economic unit (Miettinen, 2005, p. 37). The family lived in a homestead that was situated in the field that had been allocated to the family (*ibid.*). Still now, the subsistence sector, consisting of agriculture and herding, is an important part of the economy of north Namibia (NSA, 2012a). *Mahangu* (pearl millet) and sorghum are cultivated on the impoverish soil, almost all households keep goats and chickens, and a number of households own cows (Mendelsohn et al., 2000). The landscape of north-central Namibia is marked by plains and sandy soil. The semi-arid climate has rain falling mostly in the months of January to March, and the amount of water and its timing are of a great influence on the harvest (*ibid.*); droughts and floods affect the food security of households.

Children are considered important labourers in many households. For many children, key agricultural activities like collecting firewood and water, ploughing, cooking (mostly girls) and tending the animals (mostly boys) are prominent in their early years (Van der Brug, 2011, p. 45). This allocation of tasks is quite similar to what Tönjes (1911) observed in the early years of the 20thcentury. He notes that boys were obliged to assist their fathers in various tasks from a young age, and girls their mothers. For instance, a boy's duty was to look after the grazing cattle (p. 59). In particular, calves and goats were left in the care of young children (p. 60). The tasks of girls were to fetch water, pound millet and cook the porridge (p. 61). Young boys and girls were responsible for collecting firewood and often carried younger siblings on their back. Children also had certain rights: for instance, children were often allocated a small patch of the field, which they could use for cultivation (p. 65).

Kinship, love relationships and fosterage

The pre-colonial Ovambo social system had two foundations: clan-based kinship and the nuclear family (Miettinen, 2005, p. 48). Matrilineal rules determined membership of a clan, thus, children became members of their mother's clan, but not of their fathers (*ibid*.). In the inheritance of personal property, such as cattle, the closest kin in the maternal clan, the eldest living brothers and the sons of the eldest sisters, were therefore the most important claimants when a married man died (*ibid*.). His wife or children could not claim a part of the inheritance and were thus vulnerable to economic insecurity after his death (*ibid*.). When a woman died, her children, her mother or other more distant matrilineal relatives inherited her property (Miettinen, 2005, p. 49). Matrilineal inheritance is still the dominant pattern in redistributing wealth today (*ibid*.). However, this system is also subject to change in recent years as widows have been increasingly recognised as primary caregivers to many orphans (Brown, 2009); this co-existence of both systems of inheritance also came forth in my study, as is described in Chapter 5.

The other social unit, the family, consisted of a husband, his wife(s) and children (Miettinen, 2005, p. 50). In pre-colonial times, the children's place of residence was patrilocal, and they lived with both of their parents (p. 52). Nonetheless, Malan (1980) notes that the current rule of residence is neolocal – a married couple generally establishes their own household in a new locality (p. 83). Within the matrilineal system, a father in pre-colonial times had certain rights and obligations towards his children – some of these rules still apply nowadays. For instance, fathers had the right to name giving, could use his children as labourers for cultivating the fields or herding the cattle, taught their sons the duties and tasks of men, and had a right to discipline them, but not excessively (Miettinen, 2005, p. 53-54). If the father caused a child bodily harm through beating, or killed a child of his, he was liable to pay compensation to his wife's kin. Paying a fine for child maltreatment (to the headman) is still practiced today, as demonstrated in Chapter 5. The father was, however, not legally responsible for his children's misdeeds; this was the responsibility of the child's maternal relatives (see Miettinen, 2005, p. 54.).

In order for a marriage to take place, the spouses-to-be had to be members of different clans and the girl had to participate in the initiation rite (*ohango/efundula*) (*ibid*.). In the past, the pregnancy of girls was not tolerated until they had passed the *ohango* (Aarni, 1982, p. 40). The initiation rite "legalised"

sexual relations with the wife-to-be and gave her children a legitimate status in society (Miettinen, 2005, p. 50). As is discussed in Chapter 4, practices such as initiation rites have eroded in the Namibia of today, although related taboos such as parents not discussing sexual issues with their children still exist in Namibia and other southern African countries (Wieringa, 2002). Furthermore, in more recent years relatively few Ovambos between the ages of fifteen and thirty five get married but are engaged in love relationships instead, where partners do not live together and relatives are not involved (Tersbøl, 2002). Garenne and Zwang (2006) similarly found that premarital fertility, defined as fertility before first marriage, was high in Namibia, with a percentage of 40% among the Ovambo. Tersbøl (2002) states that these relationships more often occur when people are unemployed, have a low level of education, or a low income. In such relationships, men are often thought to support the woman financially with money and goods, and have sexual access to the woman in return (*ibid*.). However, men are often engaged in multiple relationships and therefore cannot keep their promise, and women may choose multiple partners to ensure sufficient support (*ibid*.). Such relationships are likely drivers of the HIV epidemic (*ibid*.). Unwanted pregnancies, teen pregnancies and leaving children in the care of grandmothers also seem to be a consequence of these relationships (*ibid*.). In Namibia, teenage pregnancies are the second most critical reason for students to leave school (NPC, 2010, p. 78). In the current study, such family practices and structures were visible as well. A significant part of the children's and adolescents' parents seemed to have been involved in such love relationships; they were not married and had not been living together. Furthermore, a third of the female adolescent participants had one or two children before the age of 19. Due to their pregnancies, two dropped out of school, and in all cases the father of their child did not support their child financially.

Matrilineal rules also influence fosterage practices. 'Child fosterage' is often defined as care by someone other than the biological mother (Brown, 2011, p. 156). In Oshiwambo, the term *oluteka* is mostly used, which means the raising of other's people children (p. 164). In the past, when the children's mother died, children normally did not remain with the father, but the guardianship passed to maternal relatives (Miettinen, 2005, p. 55). Brown (2011), in her study of contemporary fosterage practices among Ovambo-speaking people in Namibia, similarly reports that fosterage and child-rearing arrangements are influenced by

kinship. In line with the matrilineal system, the mother's brother often plays a pivotal role in providing care through fosterage.

Parental death is just one of several reasons for child fosterage among Ovambo-speaking people; many children typically move within and outside large extended kin networks (*ibid.*). Children, education and resources are linked together in these networks, and sometimes also in networks of non-kin (*ibid.*). Fosterage can be initiated by the receiving family, or families themselves look for a fostering arrangement for their own biological child (*ibid.*). Brown distinguishes various motivations to foster a child. One reason for fosterage is that children are given 'as gifts', for instance to couples on their wedding day, as they might need children to help care for their house and animals, or to women who were unsuccessful in having their own children (p. 64) In my research, a traditional healer had received a child from a client she successfully treated. Brown (2011) also notes that namesakes and maternal grandmothers can request to foster a child, a request that was generally perceived as difficult to refuse. Children would generally stay until school age with their grandmothers to learn 'traditional ways of living' (p. 165). Furthermore, children are often fostered to families who have the economic resources to support them, caring for children through fostering can also replace debts, and caring for other's children is linked to status and esteem (*ibid*.). Another pervasive reason to foster is to give children better educational opportunities (*ibid*.). Fosterage is also related to *iixuna* (suffering); through fosterage, children suffered as they did not stay with their biological parent which in turn teaches them life lessons (p. 167).

Brown (2011) asserts that fosterage arrangements in relation to the death of a parent are mostly made before the mother's death; a transition to the new home was perceived to be easier where the child would not witness the parent's death. Fosterage would also provide children with the emotional survival skills they might need to face loss – as fosterage would be linked to personal, moral development (*ibid*.). However, siblings are often split; if possible, it was therefore often preferred to leave the child where it was brought up (*ibid*.). Brown defines 'second generation orphans' as children who have been placed in a home after the death of a parent, but where the caregiver of the new home also died (p. 169). These orphans were usually more often removed from close kin than is typical for foster children (*ibid*.). Examples of this pattern were found in my study, for instance, the double orphan Kagumbo stayed with distant relatives after closely

related caregivers had died. Nelao, who was taken care of by her grandmother after her parents died, also moved to her paternal great-aunt after her grandmother had died as well.

Religion, witchcraft and death

More than 90% of Namibian citizens identify themselves as Christian, with 75% as Protestant, including approximately 50% as Lutheran (United States Bureau of Democracy, Human Rights and Labor, 2007). Christianity arrived among the Ovambo in late 19th century (Malan, 1980). In 1870, active education and Christianisation was introduced by the Finnish Mission, and increased by Roman Catholic and Anglican missionary activities after World War One (p. 78). The Ovambo predominantly converted and identify themselves as Lutheran Christians (Miettinen, 2005).

In my study, elements of Protestant perspectives on death and afterlife were emphasized, but - often only indirectly - people also referred to the influence of spirits, and sometimes mentioned curses, poisoning, and witchcraft in relation to death. Moreover, several children mentioned the existence of various supernatural beings in their surroundings. To clarify such a context, I will briefly describe the original religion/belief system of the Ovambo. To begin with, Miettinen (2005) reports, this religion included two levels of spiritual beings. Miettinen writes: 'There was *Kalunga*, god or the ultimate force, who was mostly distant but was responsible for anything that was totally unexplainable. Then there were spirits, which were closer to the living than *Kalunga.* These were either mostly benevolent ancestral spirits or malevolent evil spirits' (p. 87). Hiltunen (1993) notes that the ancestral spirits (*aathithi*) – when they were still remembered and appeased by offerings - were thought to stay in the vicinity of their homes, fields, or trees etc., but in particular around graves and holy things (p. 35). Miettinen (2005) further states: 'This good-evil dichotomy in the spiritual world was reflected in people's daily religious life, which concentrated on securing the aid of good spirits and protecting oneself against the evil ones. The same dichotomy is also seen amongst those people who were more closely connected with the spirits than ordinary people; there were the witches and sorcerers who harmed others with the help of, or because of, the spirits and then there were the healers or diviners who were seen as the counterforce' (p. 87).As the traditional

belief system absorbed and incorporated elements of Christianity, the way *Kalunga* was perceived has transformed over time (Nampala, 2006, p. 18).

Death was considered a change of conditions; man's life did not end entirely with physical death, but when a person had died, he or she had reached the stage of 'living-dead' (Aarni, 1982, p. 70-71). Having passed through this stage, the slow change began into the nameless unity of the spirits (*ibid*.). Death was thus seen as the transition from the world of the living to the world of the ancestors (Nampala, 2006, p. 58; Miettinen, 2005, p. 80). Aarni (1982) states that the deceased communicated with the living preferably in dreams (p. 75). In my study, the child participants also mentioned the frequent appearance of the dead in their dreams, which is described in Chapter 3. Aarni (1982) concludes: 'the Ovambo's feelings regarding death were ambivalent, because the dead had to be honored, propitiated and also warded off, at the same time' (p. 74).

Witchcraft was often perceived as the 'real cause' of death (Aarni, 1982). Aarni notes: 'the Ovambo knew that most deceased, accidents, as well as most deaths were caused by the fearsome *aalodhi* that is by "witchcraft". He knew that behind all external and material dangers, there were powerful spirits, thus, nothing could happen by accident'(p. 52). Nampala (2006) similarly writes that: 'the Aawombo community had a common belief that anybody who died (no matter how old) had been bewitched (*a logwa*). So whenever anything happened to anybody, there was always the suspicion that somebody was believed to be responsible for the incident' (p. 58). These perceptions also came up in my study, where, in some cases, the underlying causes of certain deaths were believed to be witchcraft-related.

In the past, burial ceremonies were simple and mostly carried out on the same day the person had died (*ibid*.). One of the ceremonies' purposes was to get the soul of the departed accepted by other ancestral spirits, and to placate it in order to leave the living undisturbed (*ibid*.). Several grandmothers in my study remembered this way of burial, and some also referred to the dangers of the deceased on the living. For instance, a grandmother noted: 'The reason why they quickly buried the dead is because it believed that, if the stomach of the dead person goes bad and bursts, it will cast a curse on the relatives – they will all die young'. Aarni (1982) describes that mourning rites generally lasted for three to four days, and were filled with songs and tears (p. 41). Whereas, the mourning of a child's death lasted one or two days (Nampala, 2006, p. 61). According to

Nampala (2006) contemporary burial rituals are influenced by Protestantism, but also some old ways of burial have survived. For instance, reading verses from the Anglican bible has replaced the 'traditional' speech, and a church ceremony has replaced the gathering at the deceased's home as the central event of the funeral (p. 94). Old ways of burial that have survived are, for example, the changing of the entrance of the homestead when a death has occurred (*ibid.*).

Death due to AIDS is an important theme in this thesis. HIV/AIDS is a global phenomenon – surrounded by international NGOs and a medical world - which affects how death is locally dealt with. For instance, local meanings of HIV/AIDS which were mentioned by participants, such as guilt for infecting partners, 'bringing death in the family', shame and stigma might be influenced by global discussions on, and images of, HIV/AIDS. Such meanings may affect the grief experiences of children. These meanings of HIV/AIDS also influence the ways Ovambo caregivers discuss parental death with children; for example, due to HIV related stigma they continued, just as in the past, to withhold the cause of parental death from children.

1.4 RESEARCH POPULATION

1.4.1 Research area

The study took place in north-central Namibia as this region records a large volume of orphans. Many children in north-central Namibia lost their parents due to a high HIV prevalence rate in the region (see section 1.3.1.). The region receives additional orphans as well, because orphans from urban areas are often sent to their rural extended families in the northern region after the death of one or both parents (SIAPAC, 2002). The study was mainly carried out in a rural village, which is representative of other villages in the region – although the research village is not as remotely situated as some of the other villages. Although a shift to the nuclear family as a form of social organisation is occurring in northern Namibia – in urban areas more than half of all households is organised in this manner – the extended family is still the dominant household pattern (UNICEF, 1995). As the extended family comprises many forms, the term 'household' will be used throughout this study to indicate the social unit in which children live. The

definition of multi-person households by the World Programme of Agricultural Censuses is utilised in this study: 'a group of two or more persons living together who make common provision for food or other essentials for living' (Food and Agriculture Organization [FAO], 2010, p. 21).

Men are generally regarded as the head of their households, but there is also a significant number of households led by women. In the region where the research took place, 54% of the households were headed by women (NSA, 2014a). The high proportion of female-headed homes in north Namibia are often a result of the labour migration of men to the central and southern regions of Namibia (NPC, 2010). A small number of households in the region where the research took place (1.6% of all households) were headed by children aged 18 years old or younger, while 0.7 % of the households were headed by orphans (NSA, 2014a). Household sources of income in north Namibia consist of wages and salaries (including the salaries of migrant labourers), subsistence farming, elderly pensions from the government, and non-farming business income and cash remittances (NSA, 2012a). The income of households frequently consists of a combination of these different sources. Various family members often combine their income to make up the total income of a household, but one person in this household may also be responsible for a number of incomes (Mendelsohn et al., 2000). Households in a city often have close contacts with family members in the rural areas (*ibid*.), and cash remittances between such households takes place.

The largest part of the commercial life of north-central Namibia centres around two towns: Oshakati and Ondangwa. Although this economic centre is growing, the unemployment rate is substantial: 24.5% are unemployed in the region where this research took place (NSA, 2013). Namibia is currently considered by the World Bank as an upper middle income country. However, income inequality remains very high in Namibia, with an estimated Gini-coefficient of 0.64 (World Bank, 2013). This means that Namibia is among the most unequal countries in the world. In Namibia, the poor are disproportionally located in the rural areas; where people living in rural areas are twice as likely to be poor (37%) compared to urban areas (14.6%) (NSA, 2012b). In the north-central regions, the poverty incidence in 2009/10 had an average of 28.2% (NSA, 2012b). A substantial number of children in Namibia thus grow up in households that are poor. According to UNICEF (2011), an overall percentage of 44% of children in Namibia are considered poor (p. 7). The Namibia Statistical Agency (NSA) (2012)

similarly estimated child poverty levels in Namibia. The NSA relates child poverty to household income and makes a distinction between vulnerable (56%) (those at risk of falling into poverty), poor (34%) and severely poor (18%) children (p. 5-7). For the central- northern regions, the child poverty percentages range from 44 to 75% for vulnerability and from 8 to 24% for severe poverty (NSA, 2012). Unemployment is high amongst youth as well; 68% of 20-24 year olds are not in employment (Ministry of Labour and Social Welfare (MoLSW, 2008).

1.4.2 Participants

This study is based on 18 months of data collection, which took place from 2010 until 2013. A group of 20 children, aged 8-12 years (10 orphans, and a comparison group of 10 non-orphans) and their caregivers participated in this study (see Table 1-1). The children attended Grades 3 and 4 (in 2011), and the group consisted of 11 boys and 9 girls. At the start of the study, 3 children of the orphan group were double orphans and 7 children single orphans. In the course of the study, one single orphan lost his remaining parent as well, and one child of the non-orphan group who was not registered at school as orphaned turned out to be a single orphan. Twenty caregivers of the children took part in the research; grandparents, parents, aunts, a great-aunt and uncle, and a grandmother's cousin.

A group of 14 adolescents (11 orphans and 3 non-orphans; 11 girls and 3 boys), aged 16-19 (in 2010) and their caregivers participated in the study as well (see Table 1-2). The adolescents were part of a longitudinal project; they had previously participated in 2003/04 as children in a study on the worlds and experiences of orphaned children (Van der Brug, 2007), and the current study followed their lives further. In 2003, the participants attended Grades 3 to 4, at the ages of 9-12 years, and 14 caregivers participated. The group consisted at that time of 5 double orphans and 6 single orphans. Brigita, a paternal orphan in 2003, lost her mother in 2009 as well. However, in the course of the study it came to light that during the 2003 study she had not been orphaned, as her father was still alive – this information had been withheld from the child. In the current study, 10 caregivers of the adolescents took part in the research: grandmothers, great-aunts, mothers, aunts, a sister and a non-related foster caregiver of the adolescents.

Table 1-1: Orphan status, school grade, and living arrangements of the child participants in 2011

Orphans				
Name	**Orphan Status**	**School grade**	**Age (2011)**	**Residing with**
Taiwo (Boy)	Double orphan	Grade 4	11	Aunt
Festus (Boy)	Double orphan	Grade 3	9	Grandmother
Kagumbo (boy)	Double orphan	Grade 3	9	Cousin of grandmother
Liezel (girl)	Maternal orphan	Grade 4	9	Father and stepmother
Erastus (boy)	Paternal orphan	Grade 3	9	Grandfather and grandmother
Hango (boy)	Paternal orphan	Grade 4	10	Great-aunt and uncle
Helena (girl)	Paternal orphan	Grade 4	12	Mother
Helvi (girl)	Paternal orphan	Grade 3	9	Mother
Martha (girl)	Paternal orphan	Grade 3	9	Aunt
Martin (boy)	Paternal orphan	Grade 4	11	Mother
Non-orphans				
Name	**Orphan Status**	**School grade**	**Age (2011)**	**Residing with**
Trevor (boy)	Non-orphan	Grade 4	10	Parents
Nile (boy)	Non-orphan	Grade 4	10	Alternately father and mother
Silas (boy)	Non-orphan	Grade 3	11	Mother and grandmother
Nothando (girl)	Non-orphan	Grade 4	10	Mother
Imbeni (girl)	Non-orphan	Grade 4	10	Mother
Tuilika (girl)	Non-orphan	Grade 3	10	Grandmother
Veijo (boy)	Non-orphan	Grade 3	12	Grandmother
Fransina (girl)	Non-orphan	Grade 3	10	Grandmother
Charles (boy)	Non-orphan	Grade 3	8	Grandmother
Berthilde (girl)	Non-orphan	Grade 4	11	Grandmother

Notes for Table 1-1 and Table 1-2:

Note 1: These names are fictitious to protect the privacy of the informants.

Note 2: At the Namibian college of open learning (Namcol) learners can repeat Grades 10 or 12 when they have failed twice

Table 1-2: Orphan status, school grade, age, and the living arrangements of the adolescent participants in 2003 and 2012

2003 study				
Name	**Orphan Status**	**School grade**	**Age (2003)**	**Residing with**
Samuel (boy)	Double orphan	Grade 4	12	Aunt
Justin (boy)	Double orphan	Grade 4	11	Grandmother
Petrina (girl)	Double orphan	Grade 4	11	Grandmother
Nelao (girl)	Double orphan	Grade 4	10	Great-aunt
Grace (girl)	Double orphan	Grade 3	9	Grandmother
Brigita (girl)	Maternal orphan	Grade 3	9	Great-aunt
Alex (boy)	Paternal orphan	Grade 4	10	Mother
Meke (girl)	Paternal orphan	Grade 4	10	Sister of great- grandmother
Claudia (girl)	Paternal orphan	Grade 4	11	Aunt
Foibe (girl)	Paternal orphan	Grade 4	10	Aunt
Hilma (girl)	Paternal orphan	Grade 3	9	Great-aunt
Aina (girl)	Non-orphan	Grade 4	10	Father and mother
Emilia (girl)	Non-orphan	Grade 4	10	Mother
Lena (girl)	Non-orphan	Grade 4	10	Father and mother
2010/2013 study				
Name	**Orphan Status**	**School grade**	**Age (2012)**	**Residing with**
Samuel (boy)	Double orphan	Drop-out	21	Uncle
Justin (boy)	Double orphan	Drop-out	20	At the premises of his work
Petrina (girl)	Double orphan	Drop-out	20	Grandmother (with child)
Nelao (girl)	Double orphan	Drop-out	19	Sister (with child)
Grace (girl)	Double orphan	Grade 10	18	Alone
Brigita (girl)	Maternal orphan	Grade 11	18	Nunnery
Alex (boy)	Paternal orphan	Pre-college education	19	Boarding school
Meke (girl)	Paternal orphan	Grade 12	19	Grandmother (child is with mother)
Claudia (girl)	Paternal orphan	Grade 10	20	Cousin of mother
Foibe (girl)	Paternal orphan	Namcol	19	Aunt
Hilma (girl)	Paternal orphan	Grade 9	18	Great-aunt
Aina (girl)	Non-orphan	Pre-college education	19	Relatives in Windhoek
Emilia (girl)	Non-orphan	Namcol	19	Aunt (with child)
Lena (girl)	Non-orphan	Drop-out	19	Parents

For the follow-up project, the fourteen adolescents had to be traced, as some had moved from the village area to other regions in Namibia. In 2010, half of the adolescents were still living in the research village. Five of them attended Grades 8, 9 or 10 at the secondary school in the research village, and two were school-leavers who stayed at home. The rest had moved to nearby small towns for employment or boarding schools, or to villages spread over northern Namibia because they joined the households of relatives. From 2010 to 2013, additional changes occurred in their lives. Some adolescents attended pre-college education or university while others dropped out of school, repeated grades, or were in and out of employment. One girl joined a nunnery, and two had moved to the capital to look for work. Within these years, four girls had become mothers.

Eight of the 22 orphans lost one or both parents to AIDS. This is based on information from the participants themselves, their caregivers, siblings or teachers. However, the actual rate of AIDS as the parental cause of death was likely to be higher (see Chapter 4). The cause of their parent's death was unclear for a large part of the participants; less than half of them said they were not informed about this.

The orphans stayed with their single parent, or were taken care of by the extended family. Fosterage mainly took place according to matrilineal descent lines. The majority of the orphaned participants who were not taken care of by their surviving mothers resided with maternal relatives. Thus, the orphans' home situations were not homogeneous: some children grew up in nuclear families with a remaining parent; others already lived with a grandmother or an aunt prior to their parent's death; others had experienced several household and caregiver changes since the death of their parents. More than half of the non-orphaned child participants were fostered as well. They were fostered due to various reasons such as gift-giving, requests by grandmothers, economic resources of the receiving family or educational opportunities. Some of them were 'dropped' at their grandmothers' or great-aunts' households, whereby the parents did not stay in contact with the caregivers nor did they financially contribute to the care of their child.

Selection of the participants

The participants were selected through school. Villages in north-central Namibia consist of widely spaced homesteads. In such a village setup, schools are central meeting points and enable researchers to have access to the children. Reflexivity is needed when selecting children through schools, as this may overlook those who are excluded or absent, such as children who are kept at home. However, the school attendance rate of children is high in Namibia, with little difference between orphans and vulnerable children (OVC) and non-OVC (94.6 % versus 93.2%, NPC, 2010), thus the group that is potentially overlooked is small.

Both the adolescents, who were children in 2003, and the child participants of the current study had been or were now students of the primary school of the village. In 2003 the school did not register the OVC status of their pupils yet; therefore the participants were selected by the teachers at that time. The teachers did not know the family backgrounds of all pupils in their classes, though selected some children whom they knew were orphans and chose 'assumed' orphans on the grounds of poor clothing and a lack of food, as many AIDS orphaned children lived in impoverished households. It turned out that three of the fourteen selected children were not orphans; they came from families with financial difficulties arising from having a physically handicapped or mentally ill parent. Schools have increasingly started to register their OVC students, hence in the current study orphaned participants were selected randomly from OVC school registration lists. The 10 non-orphans were selected randomly from the remaining students in these grades.

The concepts of 'child' and 'adolescent' are used in this study to distinguish between the two different age groups of participants. Although this categorisation is found in texts and documents by the Namibian government, the term 'adolescent' was not used by the participants. The Namibian government's definition of orphanhood was used to select the orphans in this study. The government defines an orphan as 'a child who has lost one (single orphan) or both (double orphan) parents because of death and is under the age of 18 years' and a vulnerable child as 'a child who needs care and protection' in its National Plan of Action on Orphans and Vulnerable Children (Ministry of Gender Equality and Child Welfare (MGECW), 2007). In daily use, the term 'orphan' was applied more diversely than the abovementioned definition by adults and children in this study. It was less linked to young age; adults up to 40 or 50 whose parents had died

could still be considered as orphans. Orphanhood was, instead of losing parents during childhood, mostly linked to notions of vulnerability in relation to parental loss, such as being in need of support, being pitied by people, and staying in a household without having a job. The word 'orphan' had positive and negative connotations. For instance, when grandmothers used it to address a child in their care it was mostly meant positively; however, children however mainly used it to make fun of other children who lost their parents ('You, orphan!').

Various specialists from Namibian ministries and NGOs, and other informants in Namibia were interviewed on a range of topics. Interviews with the following experts and informants took place:

- *Ministries.* Deputy Director of Civil Registration (Ministry of Home Affairs and Immigration); Deputy Director of Child Care Services (Ministry of Gender Equality and Child Welfare (MGECW), current name: Ministry of Gender Equality, Child Development and Family Welfare); Deputy Director of Child Allowance (MGECW).
- *Social/child care services*. Social worker (MGECW, district department); Head of Social Welfare Grant Allowance (MGECW, district department); staff member children's shelter; staff member Woman and Children Protection Service (a police service).
- *Education.* Principals and 4 teachers of the primary and secondary school at the research location.
- *Health care*. Pediatrician at the clinic for antiretroviral therapy (state hospital); pharmacist (Health Centre).
- *Local authorities.* Headman of the research village; Deputy Regional Counsellor.
- *NGOs and faith-based organisations*. Director and Consultant of Lifeline/Childline (psychosocial assistance to children); Location Director of Catholic Aids Action (assisting HIV-affected adults and children); members of staff and consultant at Positive Vibes (example: 'Children's Voices project); fieldworker of Takmos (home-based care).
- *Villagers.* Household heads of 'child-headed households'; traditional healer (operating in the research village).

1.5 OUTLINE OF THE THESIS

Chapter 2 describes the methodology of this study. The methodological design is an important foundation of research on sensitive issues such as death, AIDS and treatment in households, especially when research is conducted with children, and is therefore discussed extensively. In Chapter 3, 4, 5 and 6 the research findings are presented, whereby the relevant theory is introduced before the findings are discussed. These chapters each focus on one of the four aspects of childhood grief which were discussed in the introduction of the current chapter. In order to understand the way childhood grief and socio-economic security are interwoven among Namibian orphans, Chapter 5 and 6 also sketch the economic and social situation in which orphans find themselves in northern Namibia. Chapter 7 presents the conclusions, the scientific relevance of this thesis and provides some policy and intervention recommendations.

2

METHODOLOGY

2.1 INTRODUCTION

This study deals with topics that can be considered as sensitive in nature. Many children in northern Namibia are orphaned because their parents have died of AIDS; the general unspoken atmosphere surrounding the issues of HIV and death requires a careful approach when discussing such topics. In addition, some orphans were not treated well in their foster homes. Getting insights into what is happening in the lives of these children, whereby the foster caregivers are part of the research, is therefore delicate as well. Sensitive topics are characterised by the possible emotional impact on participants (Rowling, 1999). Lee and Renzetti (1990) argue that topics can be defined as sensitive when potential costs to those participating in the research are involved, such as psychological costs like guilt, shame and embarrassment, and when participation in the research can have unwelcome consequences (p. 512). They consider bereavement as a sensitive topic; the emotional stress it can produce may be threatening for participants (Lee et al., 1990). Preventing participant distress is thus pivotal in studies on grief and bereavement, even more so when children and adolescents participate.

Talking about sensitive themes may affect the research process. Based on their quantitative survey on grieving amongst Zimbabwean orphans, Howard, Matinhure, McCurdy and Johnson (2006) conclude that a survey is 'a limited tool for exploring intensely personal questions about grief, relationships, and treatment by caregivers and others; children may avoid revealing painful or embarrassing information. Qualitative methods may give insight at greater depth and may be more likely to allow time for meaningful, mutually beneficial encounters' (p. 73). However, qualitative studies on sensitive issues may also yield little response in children. Daniel, Apila, Bjørgo and Lie (2007) noticed in their study on resilience amongst orphans in Uganda that responses often remained limited when young orphans were interviewed on their feelings about a parent's illness or death. The authors argue that despite the open-ended design of interviews and questions, which would have otherwise provided ample space to respond, the responses of young children were minimal compared to those of older adolescents – mostly due to the sensitivity of the subject (p. 113). Thus, there

appears to be a need for methods to assist researchers in talking to children about delicate issues, especially with children who are not used to voicing their opinion. In this study, a 'Kids Club method' was applied to talk with children about parental loss and their changed life situation emerging from it. This method was developed during a previous study on orphanhood in northern Namibia (Van der Brug, 2007; Van der Brug, 2011).

The overall design of this study was qualitative, ethnographic and longitudinal. Ethnography is particularly useful in understanding the ways children experience parental loss. This method enables insights into children's own accounts; through ethnographies children can thus be seen as 'competent informants about and interpreters of their own lives and the lives of others' (James, 2001, p. 250). An ethnographic approach also offers room to explore the wider social and cultural contexts of childhood bereavement. The adolescent participants of my study were part of a longitudinal project. A longitudinal approach is essential in childhood studies. Morrow and Crivello (2015) maintain that longitudinal studies are crucial for theory-building related to the life-course and trajectories, showing the intersections between structural factors and individual lives over time (p. 267-268). In this way, it can be taken seriously that the context of wider familial and social processes shapes individual biographies (p. 275). Furthermore, trust and rapport can be built, which is especially critical when talking about sensitive matters. The importance of a longitudinal approach on the study of HIV affected children has been stressed as well, as this will enhance the understanding of their experiences (Li et al, 2008). Within bereavement research, longitudinal research designs are considered important as they capture the dynamic and evolving processes of grief (Tremblay and Isreal, 1998, p. 435).

This chapter presents the methodology used in this study to talk with young participants on parental loss, paying particular attention to the role of the researcher, to ethical issues in research with children, and reports on how children and adolescents experienced their participation in the study.

2.2 THE ROLE OF THE RESEARCHER

When a researcher talks with young participants about sensitive issues, his or her role and attitude are likely to be of influence on the research process. In this section, two aspects of the researcher's role are discussed: sensitivity during interviewing, and the addressing of adult-child relations.

Sensitivity during interviewing

Scholars argue that research on loss and bereavement needs to be conducted with sensitivity, which includes appropriate interviewing skills, and an awareness to the needs of respondents. For instance, Rosenblatt (1995) notes that interviewing about emotionally charged topics requires 'excellent listening, a great deal of empathy and human warmth' (p. 150). Bereaved parents in Dyregrov's study (2004) similarly recommend that interviews should be conducted in an emphatic and cautious way, and that interviewers should be knowledgeable about the bereavement process (p. 395). Corbin and Morse (2003) conclude that sensitive interviewing skills of the researchers, in combination with a code of ethics, are essential to prevent participant distress (p. 347). The needs of participants are listed in Dyregrov's study (2004); the bereaved parents asked for enough time and quietness for the interviews, and noted that some participants might need extra time and care before, during and after the interview (p. 395). Rosenblatt (1995) writes: 'I try to move the interview away from the painful matters. I might skip questions that could be especially aversive, or I might move to an abbreviated and more upbeat interview' (p. 145). Corbin and Morse (2003) likewise add that in painful interviews topics should sometimes be abandoned based on cues from participants (p. 347). Furthermore, when one on one interviews on sensitive issues are conducted, follow-up is often recommended. For instance, in Dyregrov's study (2004), the bereaved parents advised on contact with professionals (p. 395). Similar advice is found in studies conducted with young people. Hyde, Howlett, Brady and Drennan (2005) propose post-interview debriefing when in focus groups with youth, where participants may become upset by revealing vulnerabilities.

In my study, interviews were conducted with empathy and sensitivity by carefully addressing painful topics, providing follow-ups during successive meetings and offering breaks when the children and adolescents needed it. For

instance, a boy started to cry during a focus group when talking about the death of his parents. The interpreter and I comforted the boy, and ended the focus group meeting. After the boy had taken a break, we talked with him individually about the issues which had been upsetting him. At the end of the meeting, he seemed relieved to have told his story. A number of orphans indicated experiencing nightmares after having talked about the loss of a loved one. Some non-orphaned participants said that talking about loss made them fearful that their own parent would die. I therefore continuously evaluated the impact of such discussions on the children. After parental loss was addressed for the first time, half of the group said to have experienced nightmares due to the interview. We discussed whether the children had somebody they could talk to about their nightmares, and did exercises that could help to diminish them. In the course of the research, the children had become used to talking about parental loss, and all of them reported to not have nightmares anymore.

The children's silence on painful topics was respected; children were given several opportunities to address such topics, also in individual interviews, but it was left to the child whether he or she chose to discuss it. This approach is consistent with Henderson (2006), who argues that especially in research with children in a context of a high HIV prevalence, where the grief and loss of orphans in relation to their parents' death can often only be obliquely approached, that children should choose when they feel it is appropriate to open up about such things (p. 306).

Adult-child power relations

Reflexivity on the influence of unequal power relations between child participants and adult researchers on the research process is an important theme within childhood studies (Thomas & O'Kane, 1998; Punch, 2002; Christensen, 2004; Mitchell, 2006). Evers, Notermans and Van Ommering (2011) note that 'for an adult researcher, it is probable that she/he will encounter research subjects who will act accordingly to culturally informed/ascribed notions of proper child-adult behaviour' (p. 8). In the southern African context and especially in its rural communities, cultural norms that preserve the power disparity of adults over children are common and strong, taking into account sub-regional variations (Clacherty & Donald, 2007, p. 148). Obedience and respect are frequently

emphasised within the children in many African settings, resulting in that young children are not used to speaking up or voicing their opinions to adults (LeVine et al., 1994). In the rural Ovambo context, clear hierarchal relations between adults and children were prevalent, whereby respect for adult family members and other adults in the lives of children, such as teachers, is considered important. For instance, paying respect to elders in families where traditional values are maintained is expressed by the kneeling of children when they greet adult guests, and when they are called by adults in the households. At school, teachers contribute to this power distinction by showing an authoritative attitude.

In a research setting, these norms and values can result in limited responses from child participants. Van Dijk (2008) noticed in her research on young people in child-headed households in South Africa that the participants were often shy at the start of the interviews, especially the younger children. Children perceived the researcher as an 'elder', which hindered them to talk freely as they were not accustomed to discuss their problems with adults (*ibid.*). Furthermore, adult-child power disparity might make children too shy to refuse or withdraw from participation in the study.

Most of the child participants in this study were shy in the beginning as well. They were hesitant to answers questions during group interviews and some held their hands in front of their faces when being addressed directly. In order to start a dialogue with the children reducing the adult-child disparity, for instance by sitting on the same level as the participants, proved to be helpful. Enhancement of equality through the attitude of the researcher has been described in the literature; Corsaro and Molinari (2008) note that 'several ethnographers of children have pointed to the importance of developing a participant status as an atypical, less powerful adult in research with young children' (p. 240). Furthermore, the building of a trusting relationship by being both transparent and confidential as a researcher, and giving children time to acquire trust was similarly relevant in my study. Kirk (2007) argues that methods should be used that 'allow children to feel part of the research process and which give them the maximum opportunity to provide their views' (p. 1254). The use of these approaches is discussed in the next section. Most children responded to this type of attitude and methodology, and showed increasing confidence in their behaviour towards the interpreter and myself. In the interactions with the adolescents, the adult-child disparity appeared to be less than amongst the

children, especially when the study progressed and relationships with the adolescent participants developed.

2.3 RESEARCH METHODS

In this study, multiple methods were used to gain insight into how children and adolescents experience and perceive parental loss (see Table 2-1 for an overview).

Table 2-1: Research methods employed with the various groups of participants

Participants	Methods	Total
Children	Kids Club	25 (14 orphans, 11 non-orphans)
	Focus groups	25
	Individual interviews	45
	Visual techniques	
	Art-based methods	210 drawings (colour pencil, charcoal, crayon), 60 paintings, 40 lino-cuts
	Picture taking	400 pictures
	Writing techniques	14 letters, 5 short essays
	Home visits	20
Adolescents	Individual interviews	56
	Focus groups	4
	Visual techniques	
	Art-based methods	5 drawings (charcoal, crayon), 3 paintings, 3 lino-cuts
	Writing techniques	10 essays
Caregivers	Individual interviews	33
Others	Individual interviews	25
	Focus groups	1

Children participated in an afterschool Kids Club whereby diverse methods were employed, such as focus groups, individual interviews, visual techniques and writing exercises. For the adolescents, individual interviews were the main research approach, combined with visual techniques and focus groups. Research

techniques such as drawings, paintings, writing exercises and picture taking have frequently been referred to as 'child-focused' or 'child-centred'. The use of such methods in research with children is often based on the premise that children possess different competencies than adults, and methods like drawings, pictures, sentence-completion and writing would more suitable for children's abilities (Punch, 2002, p. 322). For instance, Johnson, Pfister and Vindrola-Padros (2012) state that visual methods allow children 'to describe their lives through approaches that are more congruent with their way of seeing and relating to the world' (p. 164). However, others state that the use of such methods in research with children should be reflected upon; child-centred methods may be based on essentialist assumptions about children, and approaches which highlight the uniqueness of children have been criticised for being devaluing and patronising (Mitchell, 2006, p. 70; Hill, 2005). Besides this, so-called 'child-centred' methods can be valuable techniques in studies with adults as well. Guillemin (2004) concludes that drawings are a rich research method to explore how adults make sense of the world. For example, the use of drawings in Guillemin's heart disease study with Australian women provided an in-depth exploration of the multiplicity of disease conditions (p. 287). Christensen and James (2008) thus argue that the selection of methods within research with children should not originate from an age-based adult-child distinction, but, from the notion that the method 'should be appropriate for the people involved in the study, for its social and cultural context and for the kinds of research questions that are posed' (p. 3). However, as is noted by Scott (2008), the cognitive competences of very young children might still ask for different methods than interviews (p. 90).

Multiple methods were used in this study in order to account for the different fit with individual tastes and skills of the child participants. For instance, the 2003 study showed that some shy children seemed more at ease in expressing themselves through drawing than verbally (Van der Brug, 2011). In various studies with children, a multiple methods approach is valued as it provides participants with a broad range of capacities and preferences for expressing themselves (Crivello, Camfield & Woodhead, 2009, p. 85, 59; White, Bushin, Carpena-Méndez & NíLaoire, 2010). Furthermore, such an approach enables triangulation of the research data. Multiple methods were also used in this study in order to overcome the caveat that a single method may only provide a partial account; when supplemented by data from other methods, a more complete

picture of young people's worlds and the problems they encounter can be presented.

A further issue regarding methodology in research with children is the nature of children's participation in the research process. Bluebond-Langner and Korbin (2007, p. 241) argue that awareness of this phenomenon is based on the goal of respecting children's rights. Thomas (2012) describes that an important focus within this field is directed at forming an advanced theory of children's participation, hereby drawing on political and social theory (p. 453). Most contributions to this field deal with children's participation in public decision-making (Thomas, 2012, p. 455). Here, however, I will pay attention to an older scholarly discussion, namely how through children's participation the methodology of research with children can be improved. Thomas et al. (1998) argue that the 'validity and reliability can be improved by allowing children an active part in determining their participation and how the subject matter is approached' (p. 345). For instance, visual techniques are often considered to be participatory as children are involved in the collection and analysis of data (Johnson et al., 2012; Luttrell, 2010), can decide how to represent their worlds (White et al., 2010), create images about themselves (Christensen & James, 2008), and allows them to create a methodological frame, in which they can fill in their own meaning (Veale, 2005), up to the point of the researcher's guidance. It should be noted however, as Mitchell (2006) alerts, that children possess varied abilities and inclinations to talk about their drawings (p. 69). O'Kane (1998) further specifies that a whole study should be approached in a participatory manner (p. 38; see also Pozzo & Evers, 2016). In some studies children and adolescents may act as researchers and co-researchers (e.g. Cheney, 2011).

The children and adolescents in this study participated by describing their drawings (draw-and-tell method), other artworks and photos, so that children could clarify their visual productions and explain their ideas about their work. The participants were also asked if they wanted to talk about what they had written in their essays and letters. They were involved in the research through explorative themes; during the focus groups, topics were brought in for discussion. Children's feedback was sought after every Kids Club meeting, and when possible incorporated in a following meeting. Adolescents evaluated the Kids Club method as well – they had participated in a Kids Club during the 2003 study. This feedback provided insights into how children perceive different

research methods, and these observations were incorporated into the set-up of the Kids Club for the children of the current study.

Next to the research methods mentioned in Table 2-1, observation and participation took place. Several funerals were attended. To understand the approaches of NGOs towards bereavement and orphanhood, I joined a workshop for professionals working with bereaved clients, and took part in workshops for OVC[6]. I stayed for some time in the junior headed household of an adolescent participant to understand the household and agricultural chores of these children. However, I did not live in the research village for a long period of time but resided nearby. Although living within the research village might have given the opportunity to observe in-depth how orphaned children are treated within foster households, the many kinship linkages between different households could have made children feel less free to talk to me when I was associated with a certain household. These linkages might have additionally held caregivers back from discussing issues such as HIV. For instance, before the start of an interview I was often asked which other households I had previously visited.

Most interviews were conducted in Oshivambo, except a large part of the expert interviews[7]. Although English is the official language of Namibia and the main mode of instruction at schools, the majority of the participants did not master the language well enough to be interviewed in English. Three female interpreters assisted me during the fieldwork. The main interpreter's personal history was valuable for the research; she had become orphaned at a young age and due to this experience she was able to detect and observe orphan-related issues in interviews and during home visits, such as the position of a child in a foster household. All interviews, including the children's and adolescent's description of the visual artworks and responses to the photos and writings, were recorded and later transcribed. The transcripts were read in their entirety, then coded and categorised into broader themes using the qualitative data analysis programme NVivo. The drawings, paintings, lino-cuts and photos were analysed as well on basis of the themes that appeared in the artwork. Thus, both the visual piece and the description of it comprise the data (Guillemin, 2004). The essays and letters were translated and analysed on the basis of themes that were found in the

[6] These workshops were part of the Positive Vibes program: Children's voices.
[7] I had followed a language course OshiNdonga to understand the translation process.

writings. The following sections provide an overview of the set-up, themes, and methods used within the Kids Club approach and the methodology used in research with the adolescents. It also describes the interviews with caregivers. Hereby attention is paid to how sensitive issues are dealt with when using such methods.

2.3.1 Using a 'Kids Club Method' in research with children

Two Kids Clubs - one for orphans and one for non-orphans – were set up to meet with the child respondents in a relatively neutral setting at a time that would be least disruptive for their schoolwork. They took place once a week during the 'study' period, wherein students do homework at school. Individual interviews with the children were mainly conducted during school breaks; after school, many children had to assist in household and agricultural chores at home. The context of interviews is essential as children's responses in an interview situation are fundamentally situated (Westcott & Littleton, 2005). Children could not be asked about their life circumstances in their foster homes, in case they were not treated well by their caregivers. Free talk in foster homes proved impossible in Notermans' (2008) study on children's experiences of fosterage in east Cameroon where children indicated that they might be supervised and punished for talking about experiences at home (p. 354). Reflexivity on conducting interviews in a school setting is also needed; a school setting may evoke a test-taking mentality (Scott, 2008, p. 92); this was, however, not the case in my study. The Kids Club took place over the course of several months; meeting with children as a group over a longer period of time provided the opportunity to build confidence and trust. Blagbrough (1998) similarly notes that a stretched time frame supplies more attentive and personal information (p. 34).

For the Kids Club, we gathered in one of the classrooms of the school and blankets were spread out on the floor to create an informal and inviting setting for the discussions to take place. During the meetings, the children participated in focus group discussions, made drawings and engaged in the writing exercises. At additional meetings at the school they produced artwork under the supervision of a practising Namibian artist. The purpose of the art-based methods was two-fold; the results were handled as both research data and as artworks for the Kids and

Arts on Aids project[8]. This project included a travelling exhibition of art produced by the child and adolescent participants at different galleries and art exhibition centres in the Netherlands. The visual and writing pieces were discussed individually with the children in subsequent meetings. Children were also visited at home, but were not present during these visits or left after they had greeted us as their caregivers expected them to not interfere in adult conversations. These visits provided the opportunity to observe and examine the living circumstances of the children. Characteristics of special social environments such as the home and the school are critical in determining children's experiences and activities (Mayall, 1994, p. 127). Researching children in their different environments is thus essential in understanding children's views and their life-worlds.

Kids Club focus groups with children

Questions and themes used in research with children should be in accordance with the everyday life-worlds, knowledge, age and cultural context of the children. As is argued by Morgan, Gibbs, Maxwell and Britten (2002), access to children's meanings is complicated by the different ideas, understandings, language and social worlds of children and adults (p. 11). The themes for the Kids Clubs were attuned to information received from home visits and interviews with adolescents, and occurred in consultation with my interpreter. Table 2-2 presents an overview of the themes which were discussed during the Kids Club focus groups with orphans. The non-orphan group followed a similar program, wherein topics concerning parental loss were replaced by the loss of an important person in their lives.

The themes were structured in such a way that sufficient trust was built to discuss sensitive topics in a later phase of the study. 'Staging' of the themes was important; working from general themes such as friendship and family in the initial meetings, and only discussing issues such as the loss of parents and the impact of orphanhood on their lives during later meetings, helped children to open up. The sessions that discussed delicate topics followed a comparable approach; they started with general subjects, which led into the sensitive issues, and followed with less delicate, positive subjects. It was felt that such a set-up

[8] The exhibition shows the perspectives of orphaned and non-orphaned children and adolescents on living and growing up in a region highly affected by the HIV and AIDS epidemic.

would prevent a situation from occurring wherein children were suddenly confronted with difficult subjects, and it aimed to ensure that children would leave the Kids Club with a positive feeling. This approach is similarly mentioned by Hoppe, Wells, Morrison and Gillmore (1995) who describes this as 'phasing in'; sensitive topics in single focus groups meetings with children should only be introduced once a degree of comfort is established first (p. 109-110).

Table 2-2: Themes of the Kids Club meetings with orphans

Number of meetings	Themes of Kids Club meetings
1	Introduction, consent, confidentiality issues.
2	'Friends and family'; the role of friends in the lives of children, perceptions of family, children's home situations. Activities after school, household and agricultural chores.
2	Children's feelings and emotions, 'what makes you happy and unhappy', strategies to deal with unhappiness, support networks of children.
2	Perceptions of health, illness, and health care. Knowledge of and experience with HIV/AIDS, supernatural beings (a theme brought up by the children).
1	Differences between orphans and non-orphans, problems that children may experience after parental loss.
3	Topics related to parental loss; participation in funerals, items to remember parents, grief and bereavement, treatment of orphans in foster households.
1	Perceptions on after-life, views on policies for orphans in Namibia.
1	Evaluation of participation in the Kids Club, evaluation of the comprehensibility of survey questionnaires.
1	(One year later). Changes in the children's lives, discussing research findings.

Besides this, open-ended questions were asked in which children were not pressured to give a response. At times, sensitive questions were introduced with: 'Many children experience… how do you experience this?' The advantage of this method is that children feel at ease in knowing that their experiences are not unique and they won't stand out in the group. The disadvantage is that they can be considered a type of lead-in question. Impersonal wording was also used to help children respond to difficult topics, for instance: 'What kind of problems can orphans experience?'

Whilst in the initial focus groups children answered the questions one by one because they were shy, in later sessions lively discussions took place. In both groups, a number of participants were involved and responsive which generated good cross-talk, especially after the children had become familiar with the method. Differences in age and gender between children should be additionally acknowledged in focus groups; as such disparities might have an effect on what is said by the children (Scott, 2008, p. 100). Age differences were minimal in this study, and boys and girls were not interviewed separately because most topics did not appear to be gender sensitive. In this study, children were classmates, some of them neighbours. Children's preparedness to express their views and feelings might have been influenced by the composition of the group. Studies show that group compositions matter; Hoppe et al. (1995) in their research on children's knowledge on HIV and AIDS found that groups of friends seemed to create an atmosphere more conducive to talking than did groups of strangers, as children seemed to feel safer and more willing to express their opinion. In contrast, in the study of Morgan et al. (2002) on experiences of children living with asthma in the UK, children felt freer when they did not know each other, then the children felt empowered and supported.

Focus groups can elicit information which may not be directly obtained from individual interviews. While one-on-one contact can be intimidating for children, group interactions may facilitate communication. Group interviews have the capacity 'to capture the dynamics of group interaction and to exploit this in attempting to understand a topic', such as the jokes, responses and sensitivities of the group (Hyde et al., 2005, p. 2588, 2589). In the Kids Club focus groups, various themes were discussed in-depth due to group interaction, including differences between orphans and non-orphans, views on traditional health care, and children's knowledge on HIV/AIDS. The discussions also brought forward new

topics such as children's perceptions of supernatural beings and creatures, and punishments by caregivers. Children corrected each other during the focus groups. For instance, for the children, being identified as an orphan in class by teachers as part of the yearly OVC registration was uncomfortable, as this sometimes led to classmates laughing at them. The extract below shows that the practice of being made fun of because of orphanhood is made clearer by one child correcting the other.

VdB:	To whom did that happen?
	[Helena, Taiwo and Kagumbo raise their hands]
Martha:	They did not laugh at us Kagumbo, you remember the other day we were asked by the teacher? Nobody laughed at us.
Helena:	They said to me 'you are an orphan. Orphan!'
Martha:	Kagumbo was not laughed at!
Taiwo:	They said 'waah!'
Kagumbo:	Kenth laughed at me.
Martha:	You are lying! Kenth cannot laugh at you because he is also an orphan.

(Orphan group, Kids Club focus group)

Making use of the dynamics within a group needs to be reflected upon as it may also inhibit children from expressing their views. Veale (2005) notes that socially anxious children may feel uncomfortable with group methodologies. Lena, an adolescent participant, evaluated group interview participation as a negative experience during the 2003 study because of her shyness: 'I am a very shy person; I am not courageous to answer questions', and preferred speaking only with the researcher and interpreter. Discussions on sensitive issues within a group might also cause children to reflect on difficulties in their lives even more. Moreover, when other participants are answering, children may feel pressured to respond to questions as well, possibly even making up answers. For instance, a girl (Helena) laughed at another participant during a focus group discussion who indicated to not experience any distinction between orphans and non-orphans while some others did, saying: 'You just cannot come up with something, haha!' Veale (2005) further argues that collective methods can bring about unequal participation, that focus groups may generate false consensus, and that motivational and trust issues may prevent some children from involving themselves fully.

Hoppe et al. (1995) note that researchers disagree as to whether focus groups are effective in eliciting responses about sensitive topics, and also found in their study that in some groups personal and wide-ranging discussions were

provoked on AIDS and sexuality, but that other groups did not bring forth meaningful information. They advise that focus group moderators should be especially sensitive to the comfort level of the participants (p. 110-111). Hyde et al. (2005) observed in their focus groups interviews on sexual health with adolescents that focus groups 'have the potential to allow fears, vulnerabilities and uncertainties to come to the surface' (p. 2593).

The Kids Club focus groups elicited valuable responses about sensitive topics. The subjects discussed can be considered as more or less 'shared' sensitive information; the children related to difficult issues that were not unique in the group. Children mentioned differential treatment in foster households such as coming to school without a lunchbox while other children from the household do, and poverty as a result of orphanhood – issues shared by several group members. However, personal or confidential information such as mistreatment within a household was not revealed. This might be partly due to the type of questions, as questions that could elicit information which children might want to keep private, such as their parent's cause of death, were avoided in focus groups. However, several open-ended questions offered room for personal information, but generally these questions did not bring forth personal issues, showing that children did not wish to share these concerns in the group. When comparing both the orphan and non-orphan groups, topics such as HIV/AIDS, issues around death, and differences between orphans and non-orphans, were more freely discussed in the non-orphan group than in the orphan group, indicating that these topics were more sensitive for the orphans.

Individual interviews with children

In the individual interviews with the children, the Kids Club themes concerning parental loss were similarly discussed (see Table 2-2). These contained personal experiences of the children with a focal point such as whether the child had been informed about the cause of death and whether the child had assisted in taking care of the sick parent. Issues concerning children's health and their emotional wellbeing were only attended in the individual interviews. Individual interviews may have the advantage over focus groups that more room is offered to express personal and confidential problems. Personal issues elicited in the interviews included socially sensitive issues such as running away from the foster home, and

confidential topics such as HIV as the cause of death of a parent. The children varied in their speaking about delicate issues in the interviews; some children talked about personal and sensitive issues while others gave little personal information. This disparity may be a result of differences in problematic issues in the lives of the children, but it also seemed that some children were instructed to not talk about certain issues in their home situation. A few of the questions posed in the individual interviews were evaluated as 'difficult' by the children, such as questions about their future perspectives.

Figure 2-1: 'What I do after school': ploughing the field (Veijo)

Figure 2-2: 'What I do after school': collecting firewood and herding animals (Fransina)

Visual and writing methods

The drawing and painting instructions consisted of the same themes that structured the group and individual interviews. The first drawing exercises aimed at gaining insights into the daily lives of the children and their positive experiences, such as 'what I do after school' (Figure 2-1 and Figure 2-2) 'my family' and 'happy things in my life'. Later assignments were meant to give children the chance to express difficult aspects of their lives, for example 'something that happened in my family that I will never forget' and 'unhappy

things in my life'. Children whose parent died when they were too young to remember them wrote a short essay about 'things I would like to know about my parent' (Figure 2-3) – a suggestion made by the child participants, while the others made a drawing about a memory of their parent. Some themes were adjusted for the non-orphan group. A drawing about reduced support as a result of parental loss (Figure 2-4), a recurrent theme brought up by the orphans, was altered for the non-orphans into 'make a drawing about activities you do together with your parents or things your parents do for you'. One drawing instruction related to the impact of HIV and AIDS; 'draw a picture about how HIV affects the lives of children'. The final drawing assignment was called 'my future'.

Children were given a disposable analogue camera with 20 photo films and four days to photograph their daily activities from getting up in the morning till going to bed in the evening (Figure 2-5 and Figure 2-6). The children received basic instructions about using the camera and the ethics of picture taking were discussed such as issues of consent and intrusion (children should ask permission before taking photos of other people or their possessions). Afterwards the pictures were developed.

During the letter writing exercise children were invited to write a letter to a person who had passed away. As this might be a sensitive exercise, children were given the choice to write the letter, or make a drawing about a free topic. In the orphan group, almost all of the children chose to write a letter to their late father, mother, or grandmother who used to be the main caregiver. In the non-orphan group, half of them wrote a letter, to an aunt, grandparent, friend or cousin.

Children tended to enjoy the visual methods. Nearly all child participants evaluated drawing as the research method they liked most, and taking photos was rated positively as well. Painting was sometimes evaluated negatively due to the unfamiliarity with this technique; for most participants it was the first time that they used paint. Some children that sat near each other copied each other's drawings and paintings. Drawing together supplies possibly less useful data in terms of representing a particular child, but copying might provide information on the views of children concerning different and equal experiences, diversity and uniformity (Christensen & James, 2008, p. 163). In this study, similar drawings often corresponded to individual stories; when copied drawings were discussed

individually with the children, the drawings often related to their own experiences.

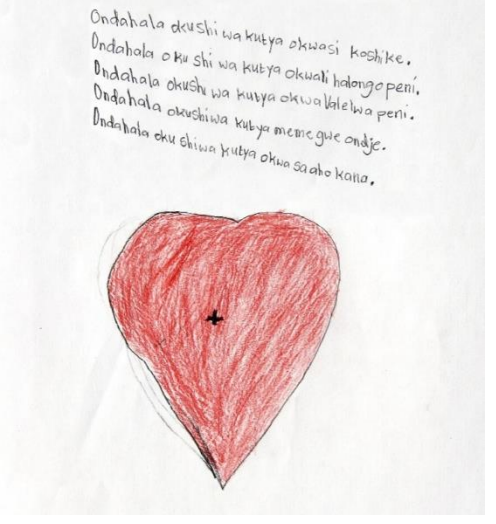

Figure 2-3: 'Things I would like to know about my father' (Helvi)

Figure 2-4: 'If my father was alive he could have bought me a bicycle' (Festus)

Figure 2-5: 'Day activities': cooking food (Boy)

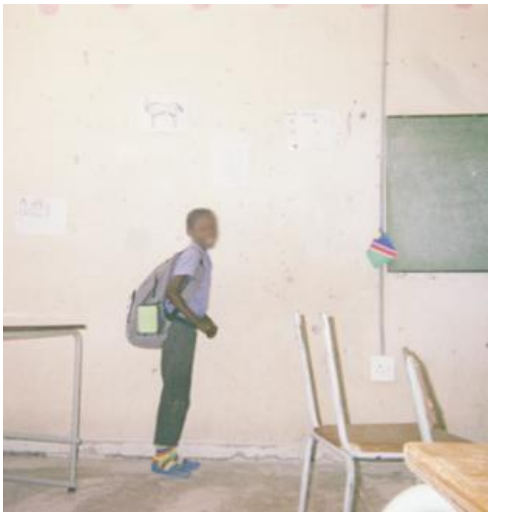

Figure 2-6: 'Day activities': attending school (Girl)

The use of drawings, paintings and pictures as a research method enabled children and adolescents to express their ideas in a visual and concrete way. As Mitchell (2006) notes, through drawings and films children 'can make their knowledge and concern visible to adults' (p. 62). For instance, abstract notions such as children's perceptions of the after-life were made clearer in the drawings than in interviews. Novel themes and information also emerged during the use of visual methods, which had previously not come forth. Lipponen, Rajala, Hilppö and Paananen (2015) state that one of the most fundamental aspects of working with visual artefacts and reflecting on them is that they offer the opportunity to see things in a new and different way. Luttrell (2010) notes that researchers using cameras with youth often observe that photographs can introduce content and topics that adults overlook or poorly understand (p. 225).

Figure 2-7: Caring for younger siblings and cousins (Girl)

Figure 2-8: AIDS medication and a sick person with HIV (Trevor)

In this study, girls' caring tasks of looking after young siblings or cousins appeared in the pictures taken by the children (Figure 2-7); a theme not brought up before by the children during discussions on daily activities or tasks. It also gave an insight into intimate home spheres such as with whom the children were sharing their hut.

Drawings sometimes also showed a more diversified picture of children's experiences and knowledge. Where in interviews only a few aspects of HIV/AIDS

were mentioned by the children, such as that people become sick and that some die, in the drawings and paintings multiple aspects of HIV were depicted. For instance, people attending hospitals, HIV medications and bedridden people (Figure 2-8), coffins, and HIV transmission through blood contact were all depicted. At other times, drawings revealed more stereotypes than the data received from interviews. Non-orphaned participants' drawings about the impact of parental loss on children showed a more stereotyped image of orphans than the information that came forth in interviews, such as that orphans often cry, walk barefoot and wear torn clothes. Campbell and Skovdall (2010) also found in their research of representations of HIV affected children in Kenya that drawings presented stereotypical and normative representations whereas the more complex and nuanced types of accounts were given in their written stories.

Children expressed sensitive themes through drawings and paintings, such as the death of a parent, being beaten by a caregiver and orphans receiving a different treatment in the house than the non-orphans. Sometimes children had not talked about these themes in the interviews. A girl whose mother died (Liezel), and who was now staying with her father and stepmother, did not mention her mother's death during interviews when themes such as family composition were discussed. Only during the assignment 'make a drawing about something that happened in the family that I will never forget', she related to her mother's death by drawing her mother's body displayed in a coffin (see Figure 3-3 in Chapter 3). This also happened in my previous study on orphanhood in Namibia (Van der Brug, 2007); a child shared the death of her father for the first time during the research in a drawing. Possibly, it is more accessible or easier for some children to draw or write about certain sensitive themes, than to talk about it. Mitchell (2006) likewise reports that 'a drawing may sometimes express what a child cannot or does not wish to say aloud' (p. 69). The abovementioned drawing assignment triggered children also to draw about images of graves.

The assignment 'make a drawing/painting about how HIV impacts the lives of children' brought forth a few paintings that drew attention. Some children made a painting or drawing about a child or person with spots on their skin (see Figure 2-9 and Figure 2-10). These paintings were not copied from each other, as one of the children was absent during the meeting and made the painting at a later point without having seen the other children's artwork. These spots seemed to be related to HIV/AIDS. For instance, the children who had made these drawings

were HIV positive themselves (information shared by a teacher), or had lost a parent to AIDS. However, when the children were asked in individual meetings to explain their painting, they said the painting depicted a person with measles. Other children referred to a HIV positive person as a person with measles as well. A boy who made a drawing of his younger brother with spots on his skin, said he had suffered from measles. However, a caregiver had revealed that his younger brother had been born HIV positive and died at a young age. Possibly, children drew a HIV positive person, but did not wish to talk about it, and said it was measles instead. Or children said measles, but actually meant AIDS-related skin rashes. Children were aware of these rashes. For instance, there had been an incident at the school; an adolescent girl had stopped taking her HIV medication and started to have skin rashes. Due to these rashes, she was bullied at school, and dropped out. After interference by the school principal, the bullying stopped; the girl started to take her medication again and returned to school. The following excerpt which is taken from the discussion of the painting displayed in Figure 2-9 shows as well that skin rashes may lead to the stigmatisation of HIV positive children:

VdB: Do you think children with HIV sometimes have pimples?
Child: Yes.
VdB: Did you see that or heard about it?
Child: I saw it with the child I was staying in the same house with.
VdB: How did you know that the child is HIV positive?
Child: We were told not to play with her, sleep close to her, not go near, just not to be with her.
VdB: You had played with her before?
Child: Yes, but then she developed things like blisters on her body, and from there we were told not to play with her again.

(Girl, individual interview)

The writing assignment ‘write a letter to a person who passed away’ elicited sensitive issues as well. The children wrote in their letter that they were missing their parent and related to the impact of the loss in their lives, such as a lack of financial support, but also issues of mistreatment were brought forward. The writing assignment ‘write a letter to a person who passed away’ elicited sensitive issues as well. The children wrote in their letter that they were missing their parent and related to the impact of the loss in their lives, such as a lack of financial support, but also issues of mistreatment were brought forward.

Figure 2-9: 'The impact of HIV on children' (Girl)

Figure 2-10: 'The impact of HIV on children' (Boy)

Generally, sensitive issues were not photographed by children. One child had made a picture of a grandmother beating a child in the household; the child participant however explained that it was good that the child was beaten as he or she had not been listening (see Chapter 6). Overall, however, the pictures gave insights into the position of children within their household. Luttrell (2010) notes in her research with working-class immigrant boys and girls in a US public school context that children often handed over their cameras to family members or friends to take a picture of them reading, doing chores or helping others. She observed that 'the most advantaged children who participated in this project (in terms of parental occupation, education and economic resources) were least likely to hand their cameras over' (p. 227). Such patterns of ownership and control also emerged from my project. Children with a good position in the household appeared more often in the pictures – photos of the child performing daily activities – then less advantaged children. These latter children reported that family members and neighbours often insisted to have pictures of them taken. For instance, a non-orphaned boy from a more advanced situation in terms of parental occupation appeared in 20 pictures whereas a double orphaned boy who stayed with distant relatives only appeared in 3 pictures.

2.3.2 Research methods with adolescents

The adolescents were predominantly interviewed individually, as many of them lived far apart. At the start of the research, four focus groups were conducted with six adolescents who attended the secondary school in the research village. During a festive meeting with nearly all adolescents, the adolescent participants created artwork under the guidance of an artist, and/or wrote essays. Johnson et al. (2012) observed in their study on young cancer survivors (5-17 years) that the older participants were hesitant to create drawings because the activity was considered 'childlike' (p. 169). In my research, adolescents felt comfortable to make drawings and paintings. It may have been stimulating that the participants could choose from various drawing and painting techniques, that the workshop was led by an artist, and that the drawings and paintings were to be exhibited.

The themes that were explored in the individual interviews included: the adolescents' experiences and perceptions of grief and bereavement;

communication practices around the death of their parent within their (foster) family; the impact of parental loss on their lives, issues within their current life circumstances; coping strategies to deal with loss and adversity; support networks; access to state provided welfare grants; and perspectives on their future. Additionally, the adolescents evaluated their participation in the 2003 study. In the focus group meetings they also evaluated their participation and discussed their current life circumstances. Furthermore, the participants were asked to 'make a drawing or write an essay about the impact of the loss of your parent(s) on your life' (Figure 2-11 and Figure 2-12).

Interviews were conducted at schools after the school day, in the fields, or at the homes of participants who were heading their own household. Generally, the adolescents felt uncomfortable to be interviewed at home; they could not speak freely because the conversation could be overheard. Some also felt uneasy to be interviewed in a place where they could be seen by village members or by peers. For instance, Samuel, an orphaned male participant, did not show up twice for an interview at the agreed meeting places (his home, and a centrally located bar), but only when we agreed to meet in the evening at the school premises did he turn up. Interviews thus took place in quiet settings out of sight. The focus groups took place in a classroom at their school.

The adolescents were more comfortable to talk about personal issues in individual interviews than in focus groups. Towards the end of the focus group meetings, the participants preferred to be further interviewed individually. This occurred despite the closeness of the group; they were schooling together, staying in the same village, and some were even friends. In one-to-one interviews they told personal and confidential information that they did not wish to express in a group 'because others talk' (Grace). Individual interviews elicited sensitive issues such as the mistreatment by a father, persistent conflicts with their caregiver, the recent death of a sister, and HIV as the cause of death of parents. Punch (2002a) similarly found that young people shared more personal thoughts and experiences in individual interviews than in focus groups. In her study about young people's problems and coping strategies in Scotland, the young people perceived the group situation as useful for matters such as memory prodding and exploring the issues broadly, while one-to-one interviews were perceived as more private and confidential. (p. 48-49). In my study, some issues, however, elicited

little response in individual interviews such as a discussion on the circumstances of their pregnancies with a number of female adolescents.

Figure 2-11: 'Reduced support in life due to death of my father' (Alex)

Figure 2-12: 'Little support in the care for my child due to the death of my parents' (Nelao)

2.3.3 Interviews with caregivers

Caregivers' perceptions on the following main themes were investigated: children's ways of grieving; mourning customs and communication practices around death within the family; the impact of parental loss on children; the foster situation of children in their care; and the financial and material support these children receive. In interviews, death related topics had to be approached carefully. Caregivers were cautious about discussing such topics because of its perceived negative consequences; talking about death might cause deaths (see Chapter 4). A careful approach consisted of asking a limited number of questions about death related topics, as a lengthy interview on the theme could raise suspicion. Alongside this, I also drafted the content of the interview questions together with my interpreter, and during the interviews she would discretely inform me when – based on the responses of the interviewee – we should move on to non-death related subjects. Furthermore, especially in interviews with the surviving parent of single orphans, talking about HIV was sensitive. For instance, one mother was most likely HIV positive as her child was HIV positive (I was informed about the child's status by a teacher). Although neither HIV nor the cause of death of her late partner was discussed with her, the interview with the mother was tense, perhaps due to the mother's suspicion that I was informed about her child's positive status. The woman refused to have her interview recorded 'because I don't know what I am going to say'. And, although she was not asked for it, she showed her health document, offered to bring the death certificate of the father, and mentioned that she did not know the cause of death of her partner. This example illustrates the sensitivity surrounding HIV.

2.4 ETHICAL CONSIDERATIONS

Child researchers agree that ethical issues are the cornerstone of research with children. Likewise, the importance of ethics is emphasised by scholars in the field of bereavement research (Rosenblatt, 1995; Cook, 1995; Stroebe, 2003; Dyregrov, 2004). Several guidelines for a comprehensive overview of ethical principles and practices are available in relation to research with children and youth. Here, the ethical standards of the American *Society for Research in Child Development* (SRCD)

have been followed. The principles of non-harmful procedures, jeopardy, consent, confidentiality, and incentives are discussed in the following sections.

Non-harmful procedures

The first principal of non-harmful procedures follows that the 'investigator should not use research procedures that may harm the child, either physically or psychologically' (SRCD, n.d.). As this study deals with sensitive and sometimes stigmatising issues, the intention to protect children and youth from harm has been of paramount importance. A general careful approach to the study was employed to minimise the risk of harm. To understand the vulnerabilities of participating children and youth, and to evaluate which research situations could be detrimental, I discussed every step of the research process with my interpreter who was experienced in working with AIDS affected children and youth. I regularly consulted with staff from NGOs working with HIV affected children, I was in contact with two psychologists who had expertise in bereavement issues, and with the local social worker. Furthermore, my professional background as a child psychologist and anthropologist, my experience from the 2003/04 study, and having worked with children affected by armed conflict, contributed to my ability to assess the vulnerabilities of these children.

A study on parental loss may be potentially harmful for young participants in different ways. Firstly, respondents could experience emotional distress as a result of talking about this topic; the section 'experiences of participation' elaborates on this issue. Secondly, orphans may become more aware of their orphan status by participating; negative remarks from fellow learners could intensify this identification as the Kids Club took place at school. It should be noted that prior to the study fellow learners already knew which participants were orphaned as teachers questioned children in class about their orphan status. Fellow learners mostly responded positively about orphan's participation in the Kids Club; these learners wanted to sign up for the Kids Club, or stated that it was nice to be part of the Kids Club. Occasionally comments about the orphan status of the participants were made, as is shown in the following excerpt from a focus group interview. Martha indicated that such comments made her 'feel bad'.

VdB: Do other children ask why you are in the Kids Club?
Martha: We are in the Kids Club because we are orphans.
VdB: Who said that?
[giggling]
Martha: Children who go on the same way as me from school.
(Orphan group, Kids Club focus group)

By participating in follow-up research the orphaned adolescents were re-identified as 'orphaned.' For some participants this process was ambivalent. Talking and thus being reminded about his late parents was uncomfortable for Samuel. He explained: 'It makes me feel bad and sometimes I feel like not responding to some of your questions…like things about my parents. I like to be asked, but about new things in my life'. Except for Samuel, most adolescents were not concerned about being re-identified in the research or identified by others as 'orphaned', as they realised many young people had lost their parents.

When discussing HIV and AIDS, care needs to be taken that children are not harmed, as children might feel obliged to answer questions asked to them, hereby disclosing information they did not intend to tell. For instance, Abebe (2009) observed that in his study with disadvantaged children in Ethiopia a few children talked in conversations with the researcher about the HIV status of family members although they wanted to keep this information secret, but that the issues came up unexpectedly. Clacherty and Donald (2007) note that in the southern African context, severe social consequences might follow when children mistakenly disclose a relative's or an acquaintance's HIV status or AIDS illness (p. 152). In this study, only two child participants mentioned HIV or AIDS as the cause of death of their parent or both parents. In an individual interview, a child told that she had been informed by her mother that her father died of HIV; she was, however, warned not to tell others, as is shown in the excerpt below. Such information clearly needs to be treated in a strictly confidential manner.

VdB: Do you tell others that your father died of HIV?
Child: I do not.
VdB: Why not?
Child: I am told not to say that by my mother.
VdB: Do you know why not?
Child: No idea.
VdB: What do you say when people ask you about the cause of death of your father?
Child: I say I have no idea.
(Girl, individual interview)

Clacherty et al. (2007) further note that (corporal) punishment is sensitive to discuss with children in the southern African context as the naming of teachers or caregivers could create the risk of further punishment if other participating children passed on this information (p. 152). In the current study, focus group discussions on punishment (a theme brought up by the children) were kept general, whereby the naming of teachers and caregivers was avoided. An additional dimension of potential harm is the temporal character of research; a researcher leaves after having developed close relationships with – sometimes vulnerable – participants over long periods of time. Possibly this creates attachment towards the research team. From the start onwards the children were informed about the duration (and temporality) of the research. Participants who perhaps needed assistance in the future received the contact details of a social worker. Alongside this, the child and adolescent participants could have ongoing contact with the interpreter who lived in the region. After the fieldwork had ended, some children had contacted her, for instance to inform about the death of a parent or sibling.

Jeopardy

A further ethical principle of the SRCD is jeopardy: 'When in the course of research, information comes to the investigator's attention that may jeopardise the child's well-being, the researcher has a responsibility to discuss the information with the parents or guardians and with those experts in the field in order that they may arrange the necessary assistance for the child' (SRCD n.d.). In this study, I referred the case of one participant to the district social worker. One of the children asked if we (the interpreter and I) could find him another place to stay, as he was treated badly in his foster household of distantly related family members where he and his sister were taken in. During the home visits, a lack of interest in the boy's wellbeing was observed as well. The child reported he was beaten regularly, received little food and had to do many household and agricultural chores. The family did not receive a foster grant for the boy, because the necessary documents to apply for the grant were missing. An additional problem included that the child was HIV positive, and during interviews with the caregivers it came to light that they had disclosed his positive status to the neighbouring houses (so that the neighbours could protect themselves from HIV transmission), resulting in

ongoing bullying of the boy by the local children. In consultation with the social worker, we discussed with the boy's caregivers that a social worker could assist them in applying for the foster grant (receiving a foster grant could improve his position in the household), but that the boy's living circumstances then had to be screened by the social worker, to which the caregivers agreed. Based on the screening, and because there were no other relatives available who could take care of the boy, the social worker placed the boy in a shelter for children upon agreement with the foster family (only one aunt in the household disagreed because she needed the boy for herding the animals) and the boy himself.

A year later, during a successive fieldwork period, we visited him in the centre. According to the staff, the boy was doing well; unlike in the past he now performed well at school, he received the nutrition he needed for his illness, and he adhered to his antiretroviral therapy, which had been in a life-threatening state when he arrived at the shelter. The boy, however, indicated he was moderately happy; he was happy to be doing well at school, but he did not have school friends as the other students did not mingle with children from the centre. Moreover, he felt he was not treated well by one of the staff members, and asked if he could be placed in another children's shelter. The social worker however decided that it was in his best interest to stay in the current centre, as this was located in the relative proximity of the boys' household, and he could maintain contact with his family. This case shows the many difficulties children who become orphaned in the context of the AIDS epidemic might experience.

Consent

The principles *informed consent*, *parental consent*, and *additional consent* (of any persons, such as schoolteachers, whose interaction is the subject of the study), are part of the ethical guidelines of SRCD. In this study, research permission was obtained from the Namibian Ministry of Education, Arts and Culture, and ethical clearance for the study was granted by the Vrije Universiteit Amsterdam. Informed written consent was obtained from the children and adolescents, the participating caregivers on behalf of themselves and the child in their care, and of teachers who participated in the research. Children and adolescents also gave their consent for the exhibition of their drawings and paintings in the Netherlands.

When informed consent is sought, participants must understand what it means to participate in terms of risks and benefits. However, as is noted by Clacherty and Donald (2007), illiteracy and absence of caregivers might be a challenge for gaining written consent in the southern African context. A meeting with the caregivers of the child participants was organised at school to inform them of the features of the research before consent was sought. When consent is sought amongst bereaved participants, Cook (1995) remarks that attention should be paid to how long after the loss of a loved one the study is undertaken. Stroebe (2003) notes that great variation exists in the period after bereavement when researchers start their study (p. 239). Most child and adolescent participants in this study lost their parent(s) at least a year ago, with the majority of them having lost their parents a number of years ago. An exception to this were a recently bereaved adolescent, Lena, and her mother (their sister and daughter had died a month before) who agreed to participate in an interview on the experience of the loss. They participated because they perceived these interviews as a remembrance of her life. An orphaned boy, Martin, who already had lost his father, lost his mother as well in between two of my fieldwork visits, and was interviewed some months after her death.

Longitudinal research brings about its own challenges in terms of consent. Fenster (2009) notes that an ethical issue is the duration of the consent once granted; thus whether consent has a specified expiration date (p. 67). Furthermore, the privacy of respondents may be compromised during the tracking process, thus another ethical dilemma is 'how much information trackers should share with collateral contacts regarding the nature of the original study or the subject's participation' (*ibid.*). In my study, this issue was not prominent, as the school principle was the main contact to track the adolescents, and he already was part of the 2003/04 study.

Reflexivity on seeking informed consent from children is needed. Adult-child power disparity in relation to the researcher or towards caregivers might influence the process of informed consent as children may feel reluctant to refuse or withdraw from participation. Clacherty et al. (2007) argue that especially in the southern African context such a discrepancy should be taken into account as 'children are expected not to gainsay adults; saying yes to participation is almost automatic' (p. 151). White et al. (2010) note that the use of informed consent procedures in a classroom context should be reflected on as well, as a formal

education setting might expect children to conform to normal classroom etiquette in the form of obedience. Besides this, it may be difficult for children to understand what participation in the study entails. Cocks (2006) thus proposes a process of seeking 'assent', when used within an ethical framework, as it 'transcends language, ability, cultural, social and international borders' (p. 247). The SRCD defines assent as a method of gaining agreement wherein 'the child shows some form of agreement to participate without necessarily comprehending the full significance of the research necessary to give informed consent.'

Consent as a process whereby children are given multiple opportunities to opt out throughout the research was used in this study as well. This was needed because the careful setup of this study complicated children's understanding of what the study was about. Although the aim was explained to the children from the start, issues such as parental loss and orphanhood were not discussed in the initial phase as these topics made children uneasy and withdrawn. As a result, many children forgot the aim as the study progressed. Moreover, I often asked consent per sensitive question. Rosenblatt (1995) similarly notes that in bereavement studies people should repeatedly be given opportunities to avoid particularly difficult questions, and states that researchers and participants thus actually co-construct ethical realities during the course of qualitative research.

Confidentiality

The SRCD defines the ethical principle of confidentiality as follows: 'The investigator should keep in confidence all information obtained about research participants. The participants' identity should be concealed in written and verbal reports of the results, as well as in informal discussion with students and colleagues'. It was explained to the child and adolescent respondents that I would not reveal anything about what they said to their caregivers, parents or teachers. Hill (2005) describes this as network confidentiality: keeping the information provided by a child or a young person secret from relatives, family or other people they know who may express an interest in what a child has said during a consultation. Likewise, the artwork was not shown to caregivers, parents and teachers. And, although the artworks were created in a group setting, after children had finished and handed in their drawings and paintings, they were not shown to the other children. Network confidentiality should also be addressed

when group interviews are used as a research method. Two rules were set: information expressed in the group interviews that could be connected with a particular child should not be told to non-participants ('everything that is said in the group, stays in the group') and children should not disclose information about the other participants during group discussions. To protect children from expressing information about themselves or their families that should not be known in the village, I tried to prevent asking questions that would elicit such facts. Nevertheless, it occurred sporadically that a participant disclosed confidential information about another child. When such an incident happened, I reminded the participants again of the rules we set. The following extract provides an example; a girl (girl 1) indicated that another girl (girl 2) was not treated well at home (in the course of the research it became clear she was not treated well by her stepmother):

VdB: Would you like to know things about your parents who passed away?
Group: No.
Girl 1: I want to know.
Girl 2: I want to know, but I would be afraid.
Girl 1: Like Girl 2, she gets beaten.

(Orphan group, Kids Club focus group)

Information that is normally withheld from participants can spread due to the research setting. Rosenblatt (1995) experienced this mechanism when conducting research with grieving families. He states: 'Thus the interviewer, even without intending to do so, may ask family members to say in front of other family members things that are far outside the usual range of what they say to each other' (p. 153). In my study, the HIV status of a late parent was disclosed unintentionally to a child during an interview. One of the child participants had lost his father when he was young. In the course of the research his mother died as well, and he now stayed alone with his brother at their homestead. I interviewed the two boys together about their changed life circumstances, and inquired about their mother's cause of death as her death came unexpectedly; she was interviewed two months before her death and seemed at that time in a good condition. The elder boy explained that their mother had been HIV positive, and although on antiretroviral therapy, he suspected that this disease caused her death. During the interview it turned out that the younger boy had not been informed about their mother's HIV status, and only now learned about it. The

older brother did not seem to find this disclosure to his younger brother problematic, as he himself was told in a similarly casual way about their mother's HIV status by their elder sister. It however left me with the uncomfortable feeling that it might have been better if the boy would have received this information in another way.

Hill (2005) employs the term public confidentiality for the concealment of the research participants' identity in research reports and presentations. He notes that especially in qualitative research special care and attention is needed to ensure that participants cannot be identified, as examples and quotes are part of the data presentation. In the research reports of this study, fictive names were used for the research participants and the location of the research setting was not mentioned. Moreover, when describing sensitive issues, for instance when the HIV status of a child or adolescent participant is mentioned, the fictive names were replaced in the research reports by the terms 'child', 'adolescent', 'boy' or 'girl', to further protect the identity of the participating child. Certain pictures and drawings which could reveal sensitive information about the young participants were not presented in the research report.

The excerpt below shows that the children in this study were concerned they were recognisable in reports, as they rightfully realised that through a researcher's name, a research location could potentially be traced. The children had addressed the problem of being registered as orphans by the teachers in their class on a yearly basis; they experienced this procedure as unpleasant, as their fellow classmates came to know about their orphan status. They were, however, afraid of the repercussions from teachers if their concerns were written down. This issue is described in the excerpt below:

VdB:	Do you think I should write your concerns down? […]
Martha:	No, it will cause us a lot of problems.
Helena:	Oh, it will bring us too many problems.
VdB:	It will just be general; your names are not mentioned.
Some:	No, we will be followed.
Martha:	It will be said that it is our school.
Hango:	You are old fashioned, why are you afraid?
VdB:	I do not mention your names, not the name of the school, not your village, and not the region your school is in.
All:	Yes, that's nice.
Helena:	Maybe say in another region.
Helena:	Or Zimbabwe.

Martha: No, just Namibia, do not mention the region.
Hango: Say what the teachers do, but do not put your name.
Helena: No, she should put her name.
Others: No – no, you want us to be followed?
Martha: You know if she puts her name, it is obvious that it is our village, because she has been here.
Martin: Yes.

(Orphan group, Kids Club focus group)

Incentives

Concerning incentives for children's research participation, the SRCD states: 'Incentives to participate in a research project must be fair and must not unduly exceed the range of incentives that the child normally experiences'. Fine and Sandstrom (1998) argue that while payment could show that the children's time is valued, it could also be seen as manipulation or create an instrumental relationship (p. 25). Hill (2005) similarly notes that amongst researchers' different opinions exists as to whether children should be paid or given small presents, as it could indicate inducement, or a fair recompense. In this study, the children were not paid for participating in the research. The Kids Club was popular, and other students asked if they could participate; paying the children of the Kids Club might have made their position even more distinct. The children were rewarded in other ways, they were provided with refreshments during the interviews and festive activities organised for them. At the end of the research the children received a new school uniform; a result of the proceeds of the exhibitions where the children's artworks were displayed and sold. The adolescents received a small payment to show that their ongoing participation in the research was valued. In addition, a party was organised for them. Some adolescents who were in need received some help, like a girl who was heading a household and lacked food as a result of a poor harvest. Caregivers received mostly food items and candles for their participation in interviews. I sometimes received gifts from caregivers as appreciation for their child's participating in the Kids Club, such as a chicken, harvest products, and baskets.

2.5 EXPERIENCES OF PARTICIPATION

This section reflects on the emotional impacts of taking part in studies containing sensitive issues on participants, and discusses how the child and adolescent participants experienced taking part in this study. Studies on bereavement with adult participants show that taking part in such studies may cause some emotional distress. For instance, in a study on bereaved parents, Dygregrov (2004) notes that 'data are often produced along with tears and crying'; the larger part of the bereaved interviewees reported it was painful to talk about the loss (p. 391). Similarly, in this study, taking part was emotional for some participants. Occasionally a child or adolescent cried during the interviews, for instance when reporting on mistreatment or when talking about the death of parents.

However, it has been argued that such distress is not necessarily caused by the research questions. Cook (1995) states that the nature of emotional distress is perceived in various ways: 'one perspective is that the questions themselves put participants in a distressed state and causes them to feel sad. An alternative interpretation is that bereaved individuals are merely expressing what they are feeling as a result of the grief experience' (p. 115). In line with the second interpretation, Corbin et al. (2003) conclude, based on a literature review, that there is no indication that emotional distress experienced by participants during qualitative interviews on sensitive issues is any greater than distress experienced in everyday life, that interviews have caused long-term harm, or that follow-up counselling is required (p. 335, 346). Rosenblatt (1995) remarks that the question as to whether a researcher has the right to carry out a study that causes people to feel emotional pain is legitimate, but also notices therapeutic effects: 'I also believe, perhaps from my own experience as much from the large bereavement literature on the importance of knowing and expressing feelings, that hurting may be a part of healing. I think bereaved people may gain enormously from talking with someone who takes their stories seriously and witnesses and acknowledges their pain' (p. 144). Thus, discussing loss in a research setting may also be beneficial for participants.

In this study, the children and adolescents evaluated how they experienced their participation at the end of the study. The adolescents also assessed their participation in the 2003 study, 7 years prior to the start of the current one. All of them experienced their overall participation positively, only a

few disliked certain research methods, as has been discussed in this chapter. They mentioned several benefits of participating in the research. Some noted that it gave them a chance to talk about their loss and loss related problems in their lives, and they felt they were being listened to. A child participant, who had disclosed about the mistreatment he experienced in his foster home, answered what he had liked about the research: 'To be asked'. Also Taiwo, who opened up during the study about the nightmares he experienced in relation to the death of his parents, said during the evaluation: 'There was nothing which was not nice in the research'. Nelao, an adolescent participant, felt she was being listened to: 'When you are asking me questions I can see that people care about me'. She recalled this from the 2003/04 study as well: 'During that time, I was always stressed. When I came to the Kids Club, I felt better, because every time you were asking questions'.

Sharing their stories with the other participants in the focus groups was perceived by the adolescent participants as encouraging and helping: 'It is good to talk with each other about our problems; it helps' (Petrina). Brigita noted: 'I liked the ideas we used to share: like how to overcome challenges that we are facing'. Grace remembered from the 2003/04 study: 'We were able to come together with other children who lost their parents and give each other advice'. The adolescents also hoped they might aid others by having told their stories, as it could raise awareness about their situation and give insight into the impact of parental loss on children. Nelao noted: 'Now the people can read our stories. If a person is acting badly towards the orphans in her house, she has to behave better when she has read our stories'. Also Justin mentioned: 'When people read about me, they are going to learn about children that have lost their parents'. Alex added: 'Then the government will know how to help the orphans'.

Similar evaluations were found in other bereavement studies. The bereaved parents in the study of Dyregrov (2004) evaluated their participation positively, which they related to the importance of telling their complete story, the format of the interview, and the importance of helping others who might find themselves in the same situation (p. 397-398). Dyregrov concludes that interviews seemed to facilitate processes of meaning reconstruction and increased awareness of the bereavement process (p. 397). In the study of Cook and Bosley (1995), the majority of the bereaved participants felt it had been beneficial to participate because it had given them the opportunity to share their feelings. It had given

them insight into their own losses, they reported to feel they could help others to understand and deal with their loss experience, and hoped to provide the society with a better awareness of the needs of grieving families (p. 163-164).

Some caregivers in the current study expressed that the children had shown more self-confidence after they had taken part in the 2003/04 study. A caregiver reported that their child was withdrawn and quiet before participating in the Kids Club, but afterwards was happy and more interactive. Increased self-confidence and empowerment as a result of taking part in the research was mentioned by some adolescent participants as well: 'It gave me the courage to battle the situation I was in and it helped me to get out' (Emilia). Samuel said: 'The Kids Club helped me to be free, free to say what I wanted. I got more information on how to communicate. I was always afraid to say something at school. In the Kids Club I learned how to be free when you want to say something'. In the Kids Club of the 2003/04 study, next to group interviews and drawings exercises, games and activity songs were also conducted with the children during breaks. As a result, the adolescents looked back on the research meetings as a place where they could temporarily forget about their problems. Emilia noted: 'Sometimes I was disappointed. When I came to the Kids Club, I felt fine again'. Alex related: 'When a child is in the Kids Club, especially those who have lost their parents, it helps to forget what is happening in their life. The child is concentrating on the things that she does in the Kids Club instead of thinking of parents that passed away. In her mind, there are things that are comforting her'. Thus, taking part seems to have been a positive experience for the adolescents.

2.6 DISCUSSION

This chapter described the methods used, including a Kids Club strategy, to talk with children and adolescents about sensitive issues such as the loss of parents in a context surrounding the HIV epidemic. The aim of this study's methodology chapter was two-fold: to show that a) the methods utilised should encourage young participants to express their experiences and perspectives, and b) at the same time the setup and procedures of the study should prevent participant distress.

Various aspects of the Kids Club approach seem to have contributed to children's expression of personal and sensitive issues. Meeting with the children over a longer period of time provided the opportunity to build confidence and trust. Working onwards from general themes in the first meetings to discussing sensitive topics only during later meetings helped children to open up. Attention to the context and setting wherein the interviews took place was similarly helpful. Furthermore, offering various methods (e.g., group interviews, individual interviews and visual and writing methods) gave children diverse ways to express themselves. The various methods appeared to elicit different types of sensitive information. In focus groups, general 'shared' sensitive information was expressed by the children, whereas during individual interviews children spoke about personal issues. Drawings sometimes showed sensitive information that children had not mentioned before – it seemed for some children less difficult to draw about certain topics than to talk about them. Adolescents preferred to talk about difficulties in their lives in individual interviews instead of in focus groups.

This chapter further shows that ethics are an important aspect of conducting research with vulnerable groups of children. This is especially crucial as a researcher could come across instances wherein the wellbeing of a participating child is at risk. The researcher's role in addressing adult-child inequality and a sensitivity in interviewing is vital as well in research on sensitive issues with children. Children and adolescents evaluated participating in the study positively; it gave them a chance to talk about difficulties in their lives, they perceived the sharing of their stories with others as encouraging, and hoped to help others by sharing their stories. For some, participating increased their self-confidence and was empowering. The evaluations show that a study on parental loss with children and adolescents in a pre-existing context where HIV and death are not openly discussed can be a positive experience for young participants, when conducted in a careful manner.

3

Childhood grief in northern Namibia

3.1 INTRODUCTION

The documented experiences of grief among African children, especially concerning the HIV and AIDS epidemic and in contexts of poverty, are limited (Van der Heijden & Swartz, 2010, p. 42). More generally there is a shortage of ethnographic and in-depth accounts of the grieving experience (Wellenkamp, 1988, p. 486; Wikan, 1988, p. 451, Noret, 2012). However, such perspectives are important as experiences and expressions of grief, as well as patterns of dealing with loss, are expected to be influenced by cultural notions (Hollan, 1995; Hemer, 2010; Gross, 2018). In order to understand the bereavement experiences of children in northern Namibia, it is therefore essential to explore Ovambo cultural notions of grief. Furthermore, the northern Namibian region has a high HIV prevalence (MoHSS, 2016), and a previously high AIDS mortality (UNAIDS, n.d.). Bereavement thus takes place within a context coloured by HIV; this may also influence the ways death and loss are dealt with.

This chapter aims to provide a culturally contextualised understanding of childhood grief by examining perceptions and experiences of orphans, non-orphans, caregivers and other informants. The questions explored in this chapter are: (i) What are the cultural norms regarding childhood grief and ways of dealing with loss in northern Namibia?, and (ii) How is grief experienced by children and adolescents in this region and what are their ways of dealing with parental death?

In the following sections the literature relating to various themes is examined where relevant for the nature of childhood grief in northern Namibia. Firstly, it gives a brief overview of characteristics of childhood grief in relation to parental loss, with special attention on AIDS-related grief. Additionally, it focuses on cultural diversity in grieving characteristics such as the duration and health consequences of grief, and on connections between the dead and the living. In these sections, different ways in which loss is dealt with are addressed as well: the role of memory and forgetting is highlighted and the 'dual process model of coping with loss' of Stroebe and Schut (1998) is discussed. Part 1 of the findings section examines perspectives on, and experiences of, childhood grief in northern Namibia, as well as children's understandings of death. Part 2 of the findings

section discusses the ways loss is dealt with, and looks into factors orphans identify as helping them to cope with their grief.

3.1.1 Childhood grief

When it comes to grief amongst children, certain characteristics are generally emphasised–based on literature from a Western context. The developmental stage of a child influences responses to death, as the cognitive capacities utilised in understanding the meaning and causes of death evolve as children age (Christ et al., 1993). While studies indicate that by 10 years of age most children have mastered components such as irreversibility, universality and personal mortality, the acquisition of some of these components appears to be differentially affected by cognitive development, verbal ability, and cultural and religious experiences (Kenyon, 2001). Children in the age of 8 till 12 tend to intellectualize death as many have not yet learned to identify feeling well (Himmebauch, Arnold and Ray, 2008). Children in this age group are often interested in physical details of dying process and interested in religious and cultural traditions surrounding death. A general consensus exists that 3 or 4 year olds are capable of 'some resemblance of grief', as children of that age have mastered object permanence (Tremblay and Israel, 1998, p. 425). However, the overt behaviour of young children differs from grieving adults; due to their inability to understand the meaning of the loss directly and an unawareness of socially expected mourning behaviours, children may appear unemotional (*ibid.*). Children's mourning also has a tendency to be more intermittent than that of adults (Siegel & Gorey, 2004, p. S67); named a "short sadness span" by Wolfenstein (1966, in Siegel et al., 2004, p. S67). Furthermore, children tend to show more somatic expressions of distress than adults as they are less capable of describing feelings, and are often deeply concerned about their own welfare such as who will be taking care of them or they wonder if they will die as well (Tremblay et al. 1998, p. 425).

When dealing with childhood grief, for instance in grief counselling, an understanding of what children know about death is important (Bonoti, Leonardi & Mastora, 2013, p. 58). Gartley and Bernasconi (1967) studied the concept of death in children from different age groups. They found that children in the age 7/8 are concerned with what happens to people when they die, children in the age

8/9 start to make a distinction between body and soul, and that they realize that they can die any time. Children aged 9/10 mentioned that there were many causes of death. They further mentioned that if a person dies, the person gets buried, the soul goes to heaven or hell, and the body decays. Children aged 10/14 mentioned less violent causes of death than younger children, and a distinction between spiritual and physical life. Gartley et al (1967) conclude that children who experienced a death in the family were especially verbal and notable matter-of-fact about the subject. Various studies have investigated whether individual differences and socio-cultural variables affect children's understanding of death (see Slaughter, 2005, for a review). Based on this review, Slaughter (2005) concludes that children's personal life experiences or their socio-cultural background, including religiosity, only influences specific subcomponents of understandings of death (p. 181). Children's overall developing cognitive competency most strongly influences their understanding of death (*ibid*.).

Childhood grief after parental death

Based on a review of Western studies on the psychological outcomes of parentally bereaved children, Dowdney (2000) concludes that children do experience grief, sadness and despair after the death of a parent, and that many children experience mild depression in the first year after parental loss (p. 827). Only a very small minority of children show characteristics of psychiatric disorders (*ibid*.). This pattern is confirmed by a longitudinal study in the United States of children and adolescents who experienced sudden parental death (Melhem et al., 2011, p. 917). In most cases, the grief reactions decreased over time; only a small number of the children and adolescents showed prolonged grief reactions, which increased the risk of depression and functional impairment (*ibid*.). Children's normative grieving responses were also examined by Silverman and Worden (1992), in the Harvard child bereavement study, whereby both American children (6-17 years) and their surviving parent were interviewed. The study worked with a non-clinical community sample and followed the families for two years after parental death, and included a matched non bereaved sample of children in the study (Silverman and Worden, 1993). The children in the study did not express acute grief responses four months after the death of a parent, such as prolonged periods of crying, aggression or withdrawal, and were able to participate in social

relations and continue with their schooling, whereby little indication was found for serious dysfunctional behaviour (Silverman et al., 1992, p. 100). The majority of the children were also not functioning poorly either at four months or at one year after the death (Silverman et al., 1993, p. 315).

Many children tried to maintain a connection to the deceased parent. Silverman et al. (1993) write: 'we found that these bereaved children devoted considerable energy to connect with the deceased in some way. They did this through dreams, by talking to the deceased, by feeling that the dead parent was watching them, by keeping things that belonged to the dead parent, by visiting the grave, and by frequently thinking about him or her (…) For the frightened children their uneasiness was related to a fear that their parent might not approve of what they were doing. Those who felt watched but were not scared were more likely to see the parent watching over them in a protective way. For whatever reason, the deceased was a real presence in most children's lives and carried on a continuation of the relationship they had before the death such as protector or disciplinarian' (p. 306). Furthermore, they state that 'children understood the concept of death in the abstract, but many had very little way of talking about this experience' (p. 315). For instance, many surviving parents were concerned that their children were not showing their true feelings (*ibid.*). It was concluded that language that is often associated with grief implies sickness, as often phrases as ''healing'', ''recovery'' and ''getting over it'' are used (p. 316). However, the Harvard child bereavement study indicates that death can be viewed as a normative life-cycle event and grief a response to loss to which all people must learn to adapt (*ibid.*).

AIDS related grief

Childhood grief after the parent had died of AIDS is often complicated due to various aspects. Firstly, many children have lost more family members to AIDS (Siegel & Gorey, 1994). Siegel et al. (1994) argue that Kastenbaum's (1977 in Siegel et al., 1994) concept "bereavement overload" which refers to the experience of multiple losses in a short time span, can also be applied to the losses of children orphaned by AIDS. The bereaved person does not have enough time to grieve a loss before another person dies when a sequence of AIDS-related deaths occur (see also Demmer, 2009). Furthermore, AIDS-related loss may be difficult for children

when parents die prematurely and they often have to witness the decay of the parent (Wood, Chase and Aggleton, 2006). Coping with a dying parent may lead to increased distress amongst children and adolescents. In a study conducted in the United States, 414 adolescents were followed for 6 years to examine the impact of HIV-related parental death (Rotheram-Borus, Weiss, Alber & Lester, 2005). The study shows that adolescents experienced high levels of emotional distress during the illness of the parent (*ibid.*). Moreover, a number of the children and adolescents who lost a parent to AIDS are HIV positive themselves, which might affect their anguish (Demmer, 2009). Questions about their own health may be intertwined with the grief of losing a parent for HIV positive children and adolescents. A further important factor that differentiates AIDS-related bereavement from other types of bereavement is the stigma attached to AIDS (Demmer, 2009); this is discussed in the next chapter. Demmer (2007) argues that in some contexts, such as in South Africa, poverty might influence the grieving of an AIDS-related death to such an extent that grief is considered to be a "luxury". For many living in poverty, the death of a loved one mixes with existing hardship (p. 825). Einarsdóttir (2004), however, contends that despite poverty and hardship, losses are also deeply grieved. Based on an ethnography within the Papel in Guinea-Bissau, Einarsdóttir indicates that Papel parents mourn their deceased infants intensely, despite a high infant mortality and extreme poverty. Furthermore, Van der Heijden et al. (2010) note that poverty may influence the grief experiences of children after an AIDS-related loss in the sense that little resources are available in communities to help children to cope with the death of a parent, such as counselling services and informed caregivers.

3.1.2 Grieving in a cultural perspective

The question as to how cultural models shape grief as a response to the death of a loved one has been explored in ethnographic studies (e.g. Wellenkamp, 1988; Wikan, 1988; Brison, 1995; Hollan, 1995; Leavitt, 1995; Hemer, 2010). These studies examined, for example, the nature of grief in Lihir, Papua New Guinea (Hemer, 2010), indigenous concepts and beliefs regarding grief and mourning among the Toraja in Indonesia (Wellenkamp, 1988), and the way individuals draw on cultural

belief to make sense of suffering in relation to the death of a child among Kwanga villagers in Papua New Guinea (Brison, 1995).

Some of these studies have addressed the question whether, despite accounts of culturally shaped grief, the actual experience of grief has universal elements. For instance, Wikan (1988) argues 'I do believe that across cultures there is a common dimension to the experience of bereavement and loss – though any particular culture's codification of the meaning of bereavement also powerfully shapes the experience, in physical and emotional terms' (p. 455). Based on her study which explored the ways culture organizes responses to loss in Muslim communities in Egypt and Bali, she notes, for example, that bereavement is also constructed out of cultural conceptions of individuality, and somatic and mental health (Wikan, 1988). In a study conducted in the United States, wherein participants with diverse cultural heritages participated, no differences were found in the individual, intrapersonal experience of grief that could be ascribed to cultural heritage or ethnicity alone (Cowles, 1996). It should be noted that despite their diverse cultural heritages, the participants were living in the United States, a shared factor which might influence their experience of grief.

In examining ways that grief is mediated by culture, a relevant theme for childhood grieving is the socialisation of the grief experience. Following Goody's (1962) notes on this phenomenon, Noret (2012) states that 'complex socialisation processes, and social experiences in general (from family relationships to religious practices and economic conditions, amongst other things), shape our perspectives on loss and death, just as our other social experiences, tastes, beliefs and practices, our dispositions to think, act and feel' (p. 274). Noret (2012) illustrates this argument with ethnographic vignettes from southern Benin, which show that funerals are often costly and extensive, partly because they are important events in terms of social relationships and identity; but also because such fitting funerals would please the deceased. As a consequence, funerals of deceased parents play a prominent role in the individuals' feelings of having fulfilled a duty towards one's parent, indicating socialised grief experiences (*ibid.)*.

Other themes are the way cultures vary in 'who has the right or obligation to grieve, who is defined as the principal mourner, and who is seen as experiencing the most loss with a given death' (Rosenblatt, 1997, p. 39). Two more subjects that received attention in the bereavement literature are, one the one hand, the duration, manifestations and health consequences of grief, and on the

other hand, connections between the living and the dead – these are discussed below.

Duration, manifestations and health consequences of grief

Cultural prescriptions may influence the accepted duration of grief. Both shortened and protracted phases of grief can be found within various cultures (Stroebe et al., 1998, p. 8). For instance, Miller and Schoenfeld (1973) found a shortened mourning time of four days amongst the Navajo, a Native American people, where after this time the bereaved should return to normal life.

Accepted manifestations of grief, such as crying, can also be influenced by cultural notions, and the perceived health consequences of grieving similarly differ cross-culturally (Stroebe et al., 1998, p. 8). Ethnographic studies on grief show that whereas in some cultures the negative impact of withholding expressions of sorrow on a person's health is emphasised, in others the risk of expressing grief is accentuated. Wikan (1988) shows a contrast between Egyptian and Balinese grief expressions and their perceived health consequences. In the Balinese community of the study, showing distress was considered socially incorrect for the bereaved, while laughter and smiling was encouraged; this was based on an underlying belief that bereavement has severe harmful consequences for a person's health, and that expressions of grief should be controlled to prevent one from this harm. In contrast, the Egyptian community encouraged crying, as expressing grief and anger is considered essential to preserving mental health (Wikan, 1988). Zhao et al. (2007) similarly note that in China children are often not allowed to strongly express grief after a death, as this is considered socially inappropriate and a sign of 'weak spirituality' (p. 1078). Wellenkamp (1988) observes that Toraja beliefs (Indonesia) about the expression of sorrow are part of an 'implicit "cathartic" theory of emotions' (p. 486). Whereas feelings of grief on other occasions than death are generally restrained, funerals are moments for expressing intense emotions; feeling sorrow after a loss is thought to bring relief by allowing the release of heavy feelings, and is viewed to prevent illness (Wellenkamp, 1988).

The danger of expressing sorrow after the conventional grieving period has ended is pointed out as well. Nordanger (2007) describes that excessive grieving and crying in Tigray, Ethiopia is perceived to negatively impact those

who grieve – it may for instance cause blindness – as well as their households, as people would be unable to support their children due to their sorrow (p. 183). Although the expression of grief is encouraged during house-mourning, afterwards grievers are urged to end their crying because of its negative consequences (p. 186). Nordanger (2007) found that Tigrans generally agreed with the dogmas of the Ethiopian Orthodox Church, which stresses the negative physical and spiritual results of excessive grieving and crying (p. 173). The Zulu participants of Demmer's (2006) study in South Africa noted that bereaved people were often told to stop crying when showing sorrow; getting depressed was perceived to be dangerous as people could 'will' themselves to die (p. 101). Nevertheless, participants indicated that, 'in reality, a lot of people continued to mourn after the funeral, but it is not the traditional way' (*ibid.*).

Connections between the living and the dead

Grief studies increasingly address connections between the living and the dead (Kaufman & Morgan, 2005, p. 323). For example, attention is paid to the continuing bonds which people have with their dead loved ones (Klass, Silverman & Nickman, 1996). Such relational grief phenomena are essential in exploring the cultural embeddedness of grief (Rosenblatt, 2013). Kaufman et al. (2005) argue that 'relationships amongst the corpse, the soul and the ritual practices of mourners continue to serve as the focal point for cultural analyses, long after Hertz (1960 [1907]) set the standard for anthropological considerations of the social ramification of death' (p. 323).

Within some cultural settings, the recently passed are perceived as a danger for the living, while those who passed a longer time ago are often seen as benevolent (Rosenblatt, 2013). Miller et al. (1973) found that the short duration of grief within the Navajo, which is characterised by not showing signs of grief nor talking about the deceased or the loss, was based on fear of the power of the spirit of the dead person which is harmful for the living. Wood, Chase and Aggleton (2006) write: 'Ethnographic research documents show that, in many African settings, children (especially those who have not reached puberty) are usually not permitted near a dead body or at funerals, being considered vulnerable to harm from death "pollution" or other dangers' (p. 1924). Goody (1962) noted in his ethnography on the Lodagaa of West Africa, that the soul of a person close to the

deceased is perceived to be at risk of joining the dead person, whereby children are thought to be particularly vulnerable. The notion of pollution is also mentioned in other African studies. In a study on Mozambican refugees in Malawi, Englund (1998) observed that the burial 'marks the phase when everything connected with the corpse becomes polluting' (p. 1169). Individuals who have worked in the graveyard must wash their hands and feet, and tools which are used for making the coffin have to be cleaned (*ibid.*). This danger of polluting 'indicates the extent to which the deceased has entered the afterworld' (*ibid.*). Amongst the Zulu in South Africa, death is similarly associated with pollution; at Zulu burials only adults are preferably present, and after the burial mourners must cleanse themselves from the pollution of death by having their heads shaven, or a lock of their hair cut off, and this hair is burned together with the clothes of the deceased (Richter & Müller, 2005).

The thinking that spirits of the dead stay in meaningful contact with the living likewise takes place in many cultural settings (Rosenblatt, 2013). For instance, in Rosenblatt's (2000) study on bereaved parents in the United States, some parents felt that they communicated with and received messages from their late child. Dreams about the deceased are sometimes interpreted as contact with the dead. Hollan (1995) found that within the Toraja in Indonesia dreams are often perceived as 'a continued experienced connection between the living and the dead' and that such visions are culturally expected and encouraged (p. 432). Dreams foretell future prosperity when the deceased are helping in the dream, but forecast death when the dreamer accompanies a dead person (Hollan, 1995). Englund (1998) argues that dreams, as well as spirit possession, are viewed by Mozambican refugees as an intrusion of the dead into the world of the living; people turn to a healer when frequent dreaming occurs, as it is considered a bad sign, bringing about madness or death.

3.1.3 Ways of dealing with loss and grief

Forgetting and remembering the dead

Studies dealing with death rituals and grief have also focused on the role of memory and forgetting in 'constituting death and the dead' (Kaufman et al., 2005, p. 323). For instance, Hemer (2010) argues that in Lihir, as in many other Papua New Guinean societies, memory is a central element in how grief is perceived and talked about. Grief is considered to follow a pattern whereby the initial phase consists of worry, sorrow and shock, however, after the mourning period a phase of forgetting and memory takes place. People are remembered through stories but at the same time, a process of forgetting is seen as the resolution of worry over a death. Hemer (2010) notes that time is seen to erase the memories of the deceased, but that also a process of memory management is carried out. Forgetting was, for instance, enhanced by passing on the name of the deceased in order to detach the name from that individual, by destroying and giving away objects belonging to the deceased, and by rituals aiming to commemorate the deceased, and forgetting of the customary debts of the deceased (Hemer, 2010). Battaglia (1992) describes that the ritual exchange of the Sabarl of Papua New Guinea shows forgetting as a 'willed transformation of memory' (p. 3). Battaglia (2012) notes: 'Sabarl regard foregrounded Segaiya exchanges as acts of "remembering" people who have died. Yet they indicate explicitly that the overall goal of Segaiya is "forgetting" both the dead and the debts that survive them as lingering impressions of their exchange histories. The "work" of forgetting is in turn cast as a procedure of removing all "traces", "marks", or "evidence" (muina) of a social existence: in the local idiom, as a procedure of "finishing" (imwa) the memory' (p. 5).

Weiss (1997) similarly stresses the connectedness of memory and forgetting in processes of memorialising of the Haya in Northwest Tanzania. He states that it is only 'by completely forgetting the "actual" deceased person – that is, eliminating the corpse of the deceased as well as the different forms that are intended to recreate him – that a "memory of the deceased" can be re-constructed' (p. 169). He gives the example of a Haya man, who made certain his daughter would not forget to wear her mourning dress, which is made out of the shroud of her deceased mother, as she would otherwise have memories about her mother and be troubled by bad dreams in which she sees her mother. He argues: 'It is as though the mourning cloth is a way of recognising and acknowledging (and

thereby remembering) the absence of the deceased, that also assures their absence (and thereby forgetting) from the productive lives of those who remain' (*ibid*.). Haya also demonstrate other acts that aid finding closure with death and produce forgetting, such as the removal and destruction of goods of the deceased. Weiss (1997) however states that forgetting not only serves memorialising: 'It is not merely that forgetting is valued because it makes memory possible – a perspective which only restores the privileged position of memory. Forgetting is an effective and productive means of assuring the assumption of onerous hierarchical connections, and dismantling the restrictive holds that the dead have on the living' (p. 172).

Hutchinson (2007, 2011) also found an important role for 'forgetting' in dealing with orphanhood. She argues that forgetting about orphanhood is not part of a dangerous conspiracy of silence but of a social process through which psychological, economic and social recovery takes place (Hutchinson, 2011). Hutchinson conducted anthropological research amongst orphans in Malawi and questioned the silence around an orphan's identity in the context of people's houses. Although in public orphanhood was discussed often, it appeared difficult to talk to children about their experiences as orphans (Hutchinson, 2007, p. 162). Hutchinson states that this hiding of the orphan identity is not caused by stigmatisation, but by the cultural notion of the importance of forgetting in the process of grieving (p. 170). Funerals provide a space to remember the dead and to feel and express emotions, however, 'once they are over, life is expected to resume as normal' (p. 171). In the same way, helping orphans 'to forget' that they are orphans, is seen as taking good care of them (p. 163). Malawian orphans are expected to recover psychologically by forgetting their past and problems, and taking on (and being taken on by) new parents - within the new household, the child will no longer be described as an orphan (Hutchinson, 2011). 'Forgetting' is hereby seen as an active process (Hutchinson, 2007, p. 166). Orphans should learn to control their thoughts, and adults (especially close kin) should not discuss their orphanhood with them (p. 163, 173). The new carers should treat the orphans well. This not only includes food and housing, but during the process of forming a new parent-child relationship, 'the adult also needs to provide the child with gifts: luxury foods (bread and biscuits), new clothes and bedding in order to show that

they were now their parent(s)' (p. 168)[9]. 'Part of the acceptance of this new relationship is the accepting of advice given to children by their new carers' (p. 174). 'Children have to acknowledge the new carers as their parents. The new parents take them on and behave as parents, and by doing so the children's identities can shift from being an orphan to not being an orphan' (p. 174-175).

Restoration-orientated versus loss-orientated ways of coping

The *Dual Process Model of Coping with Loss* (DPM) is based on the idea that the grief work hypothesis, which assumes that bereaved individuals have to work through their loss in order to come to terms with it, is not adequate enough to explain effective coping (Stroebe & Stroebe, 1993, p. 224). Subsequent theories to the construct of grief work have stressed the idea that it is essential that a bereaved person should work through loss-related negative memories, emotions and thoughts (Bonnano & Field, 2001). However, increasing evidence indicates that grief work might mostly portray the grieving process of highly distressed bereaved individuals (Bonnano, 2004). Furthermore, the notion within the grief work hypothesis that ties to a deceased person need to be relinquished to enhance adaption to loss has been complemented by the awareness that continuing a connection with a deceased person might similarly be advantageous for bereaved people (Stroebe, Schut & Boerner, 2010). Stroebe et al (1998) thus claim that next to the necessity of confronting grief, other patterns exist that lead to good adjustment, and that diverse ways of coping with bereavement occur within different individuals and cultures (p. 9). They developed the DPM (see Figure 3-1), which consists of the premise that bereaved individuals have both loss-oriented and restoration-oriented aspects to coping, but that the extent to which they undertake this varies both culturally and individually (p. 10). Loss orientation is defined as 'the dimension within which a bereaved person is concentrating on, dealing with, or processing some aspect of the loss experience itself', and restoration orientation implies 'the necessity to focus too on other aspects that come about as a result of loss' (*ibid.*). Stroebe et al. (1998) further note that avoidance of grief can take the form of a restoration approach, but that such evasion may also be a respite from coping at all. In this model, grieving is

[9] She refers to Van Velsen's (1964) notion of an orphan being a person with no one to defend them or their interests (p. 172).

perceived as a dynamic process, in which bereaved people oscillate between the two orientations of coping, which is influenced by cultural norms (*ibid.*).

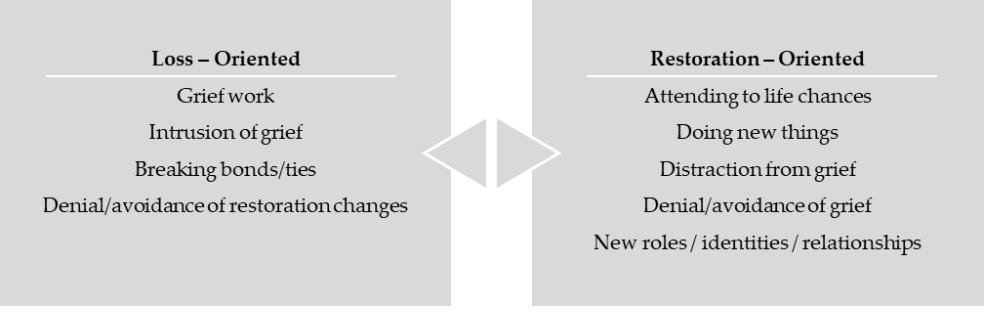

Figure 3-1: A dual process model of coping with loss (Stroebe & Schut, 1998)

3.2 RESEARCH FINDINGS PART 1: PERSPECTIVES ON, AND EXPERIENCES OF CHILDHOOD GRIEF

The first part of this section on my own findings explores how caregivers in the Ovambo community in Namibia perceive children's grief. It describes how the shielding of children from death is subject to change, and that the duration wherein children are allowed to openly show grief is limited. This section also describes children's understanding of death, and how dreams of the deceased parents are part of their grief experiences.

3.2.1 Shielding children from death

Ovambo funerals are generally centred on the homestead to which the deceased belonged. The funerals I attended went according to the following pattern. On the day of the funeral, a few days after the deceased passed away, the body was picked up from the mortuary by a group of relatives and brought to the house of the deceased. Village members, relatives and friends were present at the homestead to view the deceased, who was placed in an open coffin under a shelter. The funeral guests then relocated to the church where a remembrance service was held. Thereafter, the graveyard was attended (see Figure 3-2) where the coffin was lowered into a grave, accompanied by the singing of hymns. The

relatives and guests then returned to the house of the deceased, where meals and drinks were served.

Figure 3-2: Ovambo graveyard

In the past, children were often shielded from death until they were married or they reached the age of 18. Various mothers, grandmothers and other caregivers of the child and adolescent participants recalled that, as children, they were not allowed to attend funerals and were also often not informed about the death of a close relative. When a funeral was prepared in the home, children were sent to neighbouring houses, or had to stay in a secluded part of the house. Instead of being immediately told about a death, children were mostly informed after some weeks, or sometimes even years later. Sometimes children were informed about a death when they had noticed a new grave in the field – in the past the graves were not marked by gravestones. Other children were told that the person had gone to pick berries from the forest, or had left to another part of the country. A grandmother described this practice:

> As a child in the house you would miss the person, but you were told that the person went to the south of Namibia. You would wait and wait but the person is not coming back, only when you are maybe 20 years old you would be told that the person passed away a long time ago.

Keeping children away from death and funerals seems to be based on the belief that this would protect children from emotional distress. Caregivers noted it would help children 'to not remember a lot about the death,' and to avoid experiencing nightmares and fear. Attending the burial of their parents was thought to increase the sadness of children. In Daniel's (2005) study in Botswana, adults would explain their silence about death by stating 'it is our culture' (p. 196). Bray (2003) found similar explanations for shielding children from death in southern Africa: it would make children upset, they would not understand and would not be able to cope with the information, but adults also admitted it was a result of their own lack of courage to talk about death. Although not mentioned directly by caregiver participants in this study, notions of pollution through death might have also played a role in shielding children from death. For instance, the danger of the dead for the living is demonstrated in beliefs about the hazards of the death on breastfeeding mothers. A traditional healer explained that the spirit of the deceased mother may cause death amongst children when her surviving child would be mistreated by her relatives:

> After a person dies there must be a separation between the dead and the living. The spirits [of the deceased] part from the flesh, but these spirits do not go far away. Before the funeral, the spirits should be told: "Go with peace, and do not look back at the children, we are taking care of them". [...] When the person dies and she looks back at her children that means she is calling them because she sees that they are suffering. There would be death – children would die one after another until they all die, so you have to tell the spirits to go in peace.

As we saw, in many African settings children are usually not permitted near a dead body or at funerals for fear of harm from death 'pollution' (Wood et al, 2006, p. 1924; Englund, 1998, p. 1169; Richter et al., 2005). Hiltunen (1993) describes that Ovambo funerals were similarly characterised by pollution. Based on old written materials (from 1870 till 1932) the author notes: 'There was in Ovambo a praxis, according to which when death occurred in a family, all members of the family had to be present at the funeral in order to be purified of the contact they had with the dead' (p. 200).

More recently, the practices of not informing children about a death and keeping them away from funerals seems to have changed. In this study, the majority of the orphaned participants had been informed about the death of their parent and had attended their funeral. Figure 3-3 shows a drawing by Liezel, who depicted the funeral of her mother, when she was asked to make a drawing about 'something that I will never forget'. Meke, an adolescent participant, had gone to the funeral of her father although she had never met him. The ones who had not attended a funeral had not done so due to various reasons. Samuel had not attended the funeral of his father as he had died in Angola. Brigita, an adolescent participant, chose to not be present at the funeral of her father who committed suicide. A number of children were still shielded from death; some participants whose parent died when they were very young were considered too small to attend their funeral. They were sometimes also unaware of their burial place. For instance, Justin was only informed years after the death of his mother where her burial place was– she appeared to be buried at a nearby graveyard. He stated: 'At that time when I was not shown where she was buried, I used to wish I could have gone to her funeral, but now I have been shown where her grave is, so that is not a problem anymore'.

Orphaned and non-orphaned participants had also attended the funerals of their grandparents and relatives who were living in their homestead (some of these funerals and the grave of a relative are depicted in Figure 3-4, Figure 3-5 and Figure 3-6). For instance, a grandmother described: 'If I die today, children in the house would be told that I am dead, and on the day of the funeral they would view my face'. However, most children were not allowed to go to the funerals of relatives who did not reside in the homestead of neighbours. For instance, a large proportion of the non-orphaned participants had never attended a funeral. Funerals of schoolmates were sometimes attended. Children generally did not have specific roles during funerals. Caregivers only noted that children would sometimes sing at funerals. An expert [Shityuwete, private communication, Aug 2013] expressed her concern that children are somewhat 'lost' at funerals; they would nowadays attend funerals, but there would be no-one to guide them through the process.

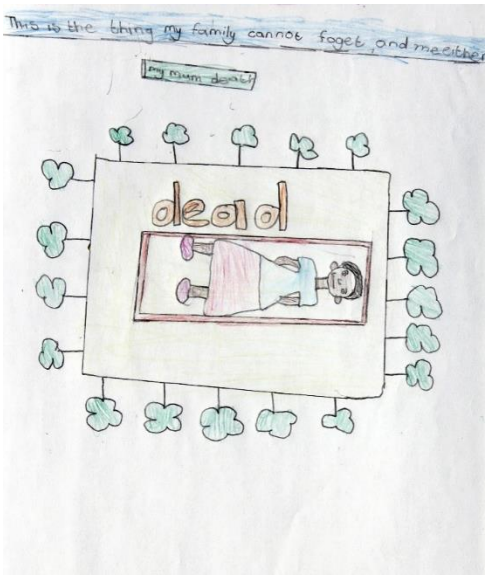

Figure 3-3: Funeral of my mother (Liezel)

Figure 3-4: 'Viewing the face' at grandfather's funeral (Helena)

Figure 3-5: Funeral of my aunt (Nile)

Figure 3-6: Gravestone on my uncle's grave (Silas)

Mixed viewpoints on changes in shielding children from death

In this study, caregivers perceived 'modernisation' and 'development' as the main general causes for the changes in shielding children from death. Several caregivers further remarked that children were now allowed to attend funerals as it was 'permitted by the church,' and it was seen to 'have become a law,' as children were additionally allowed time off from school to attend funerals of close relatives. In general, funeral rituals may change over time. As Lee and Vaughan (2012) note in their reflection on the study of death and loss in Africa: funerals are far from static institutions and 'funerary and mourning rituals are themselves subject to historical processes of change' (p. 167). For instance, contemporary professional views on allowing children to attend a funeral or burial if they want to, could have an impact on changes in shielding children from death in northern Namibia. Such views can, for example, be reflected in adapted regulations within schools about visiting funerals. However, these changes could also be influenced by the HIV/AIDS epidemic. For instance, Kiš (2008) found that in the Njolomole region in Malawi, in the past children were forbidden to attend funerals as they allegedly could be frightened by the ceremonies (p. 138). Due to the HIV/AIDS epidemic, however, funerals had become so common they were not considered a secret anymore, and children now freely attended funeral ceremonies (*ibid.*).

To notify children about the death of their parent was generally perceived by caregivers as a positive development. A grandmother explained how she informed the child in her care about the death of her mother:

> The day we received the bad news of her mother's death, I went to her and held her like this on my lap, just, as you can see, the way I have this child now. And I said: last born, you heard that your mother has been sick in hospital, now God has called her, and she is no longer with us. The girl accepted it and said: 'Grandmother, you are now my mother.'

Caregivers indicated that telling lies about the death of a parent, for instance telling that the father had gone to work, were difficult to uphold when children would start asking questions. Besides, children would later in life be 'disappointed' when they would find out that such information had been kept secret from them. Furthermore, when the funeral was held away from the homestead, it was considered impossible not to inform the child. Nevertheless, in some cases very young children were not informed about the death of a parent, but were told that the parent had gone away.

In contrast, caregivers had mixed viewpoints on whether it was beneficial for children to attend funerals and view the deceased. The main reason of caregivers who were supportive of the development included that children's attendance was 'to confirm that the person is gone, and never will be seen again'. It would help children to accept the death of a parent, and it would keep them from thinking that their father or mother might come back one day. By attending the funeral, children would know that the death of their parent was 'true'. For example, a grandmother explained that children would be shown the body of the parent, and at the cemetery see the open grave, telling the child: 'In there your mother goes and you will never see her again'. Furthermore, attending funerals was considered to have the advantage that children were informed about the burial place of their parents. Alongside this, some caregivers argued that during the funeral of their parents, children could be introduced to relatives who might support them in the future. This is also found in Zimbabwe; in their survey on 153 children and adolescents orphaned by AIDS, Howard, Matinhure, McCurdy and Johnson (2006) found that two-third of the participants had attended a funeral or *kurova guva* ('beating of the grave'), a family gathering at which inheritance and child-care decisions are made.

Those against claimed that children would deal better with the death when shielded from it. Negative effects included that children would 'become afraid or mad when seeing the lifeless body', the child would suffer from nightmares or be troubled, and the image would haunt them in their sleep. The grieving process was considered to be shortened when the child was shielded from these experiences, and it was said that the child 'would forget better' when it was told that the father had died instead of attending his funeral. Some caregivers thus did not allow children in their care to attend funerals.

Although most children expressed that they wanted to attend the funerals of loved ones, the children also indicated that going to the funerals made them 'feel bad,' and a few stated that it would give them nightmares. The orphaned adolescents felt it had been helpful for them to be present at their parent's funeral. The main reasons that were given included were: 'To believe that your mother is gone' (Brigita), and 'You will remember things about the funeral, and you see her for the last time when you are checking her face' (Nelao). For Lena the funeral of her sister helped her to accept her death: 'I did not believe that she was dead

before the funeral, but at the funeral when I viewed the body, then I believed that she was truly dead'.

3.2.2 Restricted duration of expressing grief

The mourning period amongst the Ovambo generally covers the time from the death of the deceased till the funeral. This period is often characterised by the following practices. After the news about the death is brought to the homestead of the deceased, relatives and neighbours are informed about the death. Neighbours leave their houses to meet the people who were taking care of the deceased in the hospital when they return home. Relatives bring tents to stay over for the mourning period and assist in the funeral preparations. A cow is slaughtered to feed the funeral guests. Hymns are sung. Elder women adorn black scarves tied around their head. At the funeral, wives and mothers of the deceased wear black dresses. Relatives and friends often wear t-shirts with a printed photo of the deceased. Close relatives stay for an additional day after the funeral to assist the household members. In these days, possessions of the deceased are displayed and divided. Belongings which cannot be used by others are burnt.

Children were generally allowed to grieve openly during the mourning period, until the funeral. Caregivers identified shock and crying as the most common acute manifestations of grief amongst children, and quietness as a less common grief response to the loss of a parent or other close relative. Crying during the mourning period was perceived to be healthy as it relieved pain and anger. When children and adolescents were seen to cry silently, they were often encouraged to cry loudly. Children might experience shock when they were told the news of the death. Shock was described by caregivers as a condition in which the child was crying continuously, when a child was sobbing 'from the day the news breaks until the day of the funeral,' or when the child was crying so much that he or she would pass out. A caregiver explained that shock and sadness would only be present before the burial, and that it mostly occurred when a child had difficulties to believe that the person had died.

A few remedies were distinguished to treat shock and intense crying. These remedies were mostly given when a child sobbed intensely, but could also be given before the news of the death in order to prevent shock, or when a child

was very quiet and refused to eat. Their function was to strengthen and calm the child, and was similarly given to adults. In the past, a bereaved person was given water to drink from the hole of the axe (the strength of the axe would make a person strong); water with a stone inside; water from a stone which was used to sharpen an axe; or water that had been laying on the clothes of the deceased. Also, certain herbs were given to chew on to lessen the shock. Although not practiced much anymore, caregivers stated these remedies were still effective. More contemporary remedies given to children were sugar water and water with charcoal, which were seen to 'calm the heart'. In the case of shock, the child could be taken to the hospital for sedatives. The use of charcoal in relation to death amongst the Ovambo is similarly mentioned by Hiltunen (1993); a family member of a deceased person who returned home after a death had occurred and missed the funeral, had to gnaw charcoal before entering the house. The contact with the spirit of the deceased was neutralised in this way, and charcoal was believed to protect against misfortune. (p. 200-201).

After the funeral, children were not supposed to express their grief publicly anymore. Caregivers stated that it was 'not good' when the normal grieving period of children was exceeded. Especially crying was seen as 'unnecessary' and would not 'change the fact that the person is gone'. The mentioning of the deceased parent was likewise considered inappropriate; this emphasis on acceptance and forgetting is discussed further on in this chapter. Thus, as a grandmother explained:

> After viewing the body and observing a person being buried, you have to accept that the person is gone. A child does not need to keep crying.

The crying of a child after the mourning period was generally also considered to be unhealthy. Most of the caregivers were of the opinion that if a child cried after the mourning period it had to be taken for counselling to a community child care worker, or brought to the hospital, as 'the child's heart is in trouble'. However, some caregivers thought that a child should be asked what caused the crying. Others comforted sad children by singing hymns with the child, and argued that children should not be left alone and instead be surrounded by others. A few indicated that crying as a response to parental death should be allowed over a longer period of time; like for a number of weeks or a month after the parent had passed away. A younger caregiver, an aunt who was taking care of her orphaned

nephew, thought that a child should be able to show grief at any moment because 'if a child feels like crying, it should release its tears' and questioned the practice to tell children to stop crying as it might make children feel better.

Although children should not cry openly anymore after the funeral, caregivers felt that a child could stay sad after parental death. Generally, such sorrow was viewed as short-lived and would disappear soon after the funeral, but some caregivers recognised that children remain sad for a longer period of time. In particular, the days after the funeral were seen as difficult for children. A few caregivers considered sadness to be a long process as with every death in the village and every funeral attendance, children would be reminded about their loss. Children's sadness was seen as an inward experience: 'Sadness is in the heart,' which children expressed by showing withdrawn behaviour such as not playing with others or not being productive. Some caregivers observed that a child would be crying alone where others could not see them. A grandmother observed such withdrawn behaviour in an orphan she was taking care of:

> If a child loses the parent, like the sister of Kagumbo here, sometimes the child misses things she used to do with her mother and she would cry about that, but not in front of us, she cries alone so that people do not see her.

Whether the child had known or stayed with the parent was considered to increase the sadness of the child. A child who did not grow up in the household of the parent was seen to experience little grief after that parent had died. For instance, a caregiver, the great aunt of the orphaned adolescent Brigita mentioned that the child did not show sadness after the recent death of her mother. She thought this was due to the fact that Brigita had always lived with her, even at the time that her mother had been alive, resulting in that she had not known her mother well. Thus, contexts of fosterage within the Ovambo seem to influence perceptions of how children experience grief after the death of a parent. Caregivers mostly responded to sadness by making jokes and by comforting the child. The sadness that children experienced was seen to be similar to that experienced by adults, as both had lost a loved one. However, the sorrow was seen to be more internal 'it is more in the heart,' and not as long lasting as with adults.

Children confirmed that the period in which they were allowed to cry was, in general, limited; they were allowed to cry until the funeral and maybe one

or two additional days afterwards. When this period was exceeded, children were told to stop crying. Children's reasons of why they were not allowed to cry corresponded to adults' explanations, such as crying being harmful for their health 'it would make you sick' (Frieda) and acceptance that 'the person is already gone' (Tuilika). Children generally said they were feeling sad or unhappy, to express how they felt when a loved one died. Sadness was felt by most children in the heart 'the heart is heavy,' but also in the mind. In the abstract below, one of the adolescents (Lena) described her mood and emotions after her sister had died:

> I was feeling sad. I was afraid because I did not know what caused the death. I lost my appetite and it felt like my stomach had expanded. I felt weak and could not do anything, I just wanted to sleep. I slept in the morning and again in the afternoon until in the evening. I did not believe that my sister died before the funeral. But at the funeral when I viewed the body, I then believed that she was truly dead.

3.2.3 Children's understandings of death

Children perceived death as irreversible. This resembled the opinions of most caregivers who considered children from the age of 6 or 7 years onwards capable of understanding the irreversibility of death, and is in line with the literature on children's understanding of death (Slaughter, 2005; Kenyon, 2001).

Furthermore, both natural and supernatural explanatory models of death were found. All child participants stated that after a person had died, the body was put in a grave and that 'the person would become bones' or that 'the body would be eaten up by worms'. At the same time, children expressed a belief in a Christian afterlife. Heaven and hell, and God and Satan were mentioned by the children as the place where people go to after their death. A distinction was made between the body and the soul of the person; the soul went to 'father God' or to heaven, whereas the body would stay in the grave. Another after-life place was mentioned as well; here only ghosts existed. A person would be called in his sleep by ghosts, mostly deceased family members, and was told to follow them; the following morning the person would be dead. Lagare, Evans, Rosengren and Harris (2009) likewise found both explanatory models of death among children growing up in the predominantly Catholic structure of Madrid, Spain and also among Venzo children and adults of Western Madagascar, whose belief systems involves the worship of the ancestors (see Astuti & Harris, 2008). No evidence was

found in either cultural setting that the acquisition of a biological understanding of death undermines or displaces a belief in an afterlife, in terms of the Christian heaven or the life of the ancestors (Lagare et al., 2009).

In my study, children had distinct ideas about how the 'soul' would reach heaven. The deceased person would follow a path which would lead him or her to heaven (Kagumbo); a soul was taken by God when a strong wind was blowing (Taiwo); an angel would push a person up to heaven (Martha); 'If the soul is taken, it sounds like someone is inhaling with a lot of energy and when it reaches heaven it sounds like exhaling' (Hango); 'When you are buried you will see a red thread coming down from heaven, you will catch it and hold on to that thread and it will take you to heaven' (Frieda). The latter is depicted in Figure 3-7. Heaven was pictured to be 'high up' beyond the moon and stars, Figure 3-8. Mixed opinions existed about where hell was placed; deep down under the ground or between Earth and heaven. Heaven or 'the house of God' was imagined as a nice place with various fruit trees, mountains, plants, wild animals, water, clouds, butterflies and birds. Some children stated that God was present in heaven, as well as angels with wings. Others imagined people to wear white clothes in heaven, and the clothes could not become dirty (Fransina), or that in heaven people could not fall sick (Nile). Saveria noted: 'If I did not sin my angel will welcome me in heaven with its wings.' Hell, or the 'house of Satan' was depicted in children's drawings as a fire, with people burning there. Children had heard from caregivers that hell was very hot, 'Even the chairs are hot, you cannot sit on them' (Helena), 'Those who are in hell will have burning wounds, but you will not get burnt up' (Martha). Children also had heard that 'those who died and they are with Satan, they do not eat, just one grape would be thrown at them, whoever catches it is lucky' (Berthilde). Others stated that Satan would eat people (Taiwo).

Most children agreed that the majority of the people would go to heaven. People would go to heaven when 'they worked for God' and 'obeyed God's commands'. At the same time, some noted that many people would go to hell. 'Insulting other people' was most often mentioned as a reason to go to hell, as well as killing people, committing suicide, working for Satan, having bad manners and lying. Resurrection from death was mentioned as well.

Figure 3-7: A deceased person is taken to heaven (Frieda)

Figure 3-8: Heaven is beyond the stars (Veijo)

A boy (Nile) was of the opinion that his late aunt would come back one day, after a long time, as he had heard in church. Resurrection was imagined as 'The heaven will crack and people will climb down on the ladder and will go back to the places they came from' (Helena), or that new people would be created by God. It seemed that children based their ideas of heaven and hell on information from relatives (mother, siblings, aunts), the church, or on what they had read in the bible, saw on pictures, or heard about on the radio and in movies.

Although most children had an image of life after death, only a few related this to their deceased parents. The majority of the children indicated they did not think about where their late parents were, only a few stated that their parent was in heaven (Helvi), 'by father God' (Taiwo), or ululating in heaven (Kagumbo). Trevor, who recently lost an older sister, indicated that 'if you have siblings that have died, you will meet them in heaven.'

3.2.4 Dreams about deceased parents

Many orphaned children experienced dreams about the late parents or other deceased caregivers such as grandparents. Non-orphaned children additionally had dreams about close relatives who passed away. The occurrence of these dreams differed from regular amongst some to seldom for others. Although dreams about deceased parents sometimes appeared by themselves, mostly the dreams happened after people had been talking about the deceased person, or when children had been thinking about the parent. During the research, the double orphan Taiwo opened up in interviews about the dreams he had about his deceased parents, and his deceased grandmother who took care of him after the death of his parents. After the death of his grandmother, his aunt, who already lived in the homestead, took care of him. His aunt did not talk with him about his losses. The following case of Taiwo gives insight into how children experience such dreams.

> Taiwo regularly dreamed at night about his late parents, especially when people had been talking about them. When he was asleep, images of his parents appeared in his dreams, as some sort of shadows. He was afraid of these shadows, 'it is an ugly thing,' and he started to cry when he saw them. He would wake up from the images and one day he tried to follow them until the door of his house. Taiwo only possessed one picture of his mother, and the shadow that resembled his mother, is similar to this

> picture. He saw these shadows for a long time already, but did not discuss seeing these images with anyone in the house. The interpreter advised Taiwo to say a prayer before going to bed in the evening in order to stop the dreams: 'God protect me, I am your child'. A few months later Taiwo did not dream about his parents anymore. He felt it helped that he started praying: 'I pray that father God helps me to not have these nightmares again'. Instead he now dreamt of his grandmother who passed away a few weeks earlier. In the dreams he interacts with his grandmother: 'I dream of her sending me somewhere, I wake up when I am giving her what she sent me for'. Again a few months later, the dreams about his parents returned, including the dreams about his grandmother. The dreams did not make him afraid anymore, as he stopped seeing the shadows. However, he wished these dreams would stop as he continued to meet his late parents and grandmother in these dreams.

Taiwo thus saw his parents' shadows in his dreams. In his account of Ovambo religion and spirituality from 1870 onwards, Aarni (1982) writes about the relationship between shadows and spirits. He notes that Ovambo thought that the *aathithi (*the dead became aathithi), could interfere in the affairs of the living (p. 64). It was believed that they appeared as shadows (shades): 'the shades are people. They are of us. One day we will be shades' (p. 64). Aarni notes that dreams at night were a way for the deceased to make themselves visible to their relatives (p. 47). He notes that Ovambos considered contents of dreams often as part of reality: 'If someone has been dreaming of his grandfather during the night, then his grandfather, in accordance to his belief, had actually visited him and talked to him during the night' (p. 69). Aarni (1982) further writes: 'The absence of dreams can indicate a lack of interest on part of the shades. On the other hand, if the spirits or the living-dead appear too often to human beings, people feel disturbed' (p. 70). These themes appeared in the stories of the children in the current study as well.

Interactions with the deceased were the main topics of the children's dreams: 'I dream of my father and me coming from church' (Erastus), 'I dream of my grandfather carrying me over his shoulders' (Joseph), 'I dream of him coming to pick me up' (Helvi), and 'I dream of my sister busy cooking' (Trevor), 'I dream about my father giving me food to take to school' (Kagumbo). Children also dreamt about the presence of the deceased in their room: 'I have dreams about my grandmother sleeping in the same bed as me' (Taiwo), or of images of the parent's

dead body. Adolescents also dreamt about deceased relatives: 'I dream that when she appears she beats me, which is like she does not love me anymore' (Lena).

The dreams were perceived negatively by the children. The dreams made them scared, and fearful to go to bed; they would pull the blanket up over their heads. The dreams also made them think about their parents. Some children woke up from these dreams, wanting to meet or chase the person in their dreams. For instance, Helena described that she woke up from her dream about her late father and that she walked to the door of her hut to meet him. The majority of the children did not talk with anybody about these dreams, while a few discussed the dreams with their grandmothers or mothers. Grandmothers mostly comforted the children by telling the children 'dreams are just like that' and children were also invited by their mothers or grandmothers to sleep in their room. Other caregivers responded to the content of the dreams, by telling the child that the deceased parent had loved him or her, or showed the child a picture of its late parent. Other responses inhibited children from talking about their dreams: 'If I tell my mother, she cries, so I stopped doing that' (Helena). While some children found it beneficial to discuss such dreams 'it goes away from your heart' (Kagumbo), others did not find it helpful as the child would think even more about the death of their parent.

Children's dreams about deceased parents were explained in three ways. First, dreaming was mostly related to the child thinking about their parent. Caregivers indicated that dreams about deceased parents often meant that the child did not forget about the person. A distinction was made between 'dreaming in a light way' which could be helpful in the grieving process of a child, and dreams about seeing coffins or graveyards which could cause 'disturbance in the mind of the child'. Such dreams were not considered real dreams, but their thoughts about their parent's death. A traditional healer stated that the dreams of children were, for instance, actually thoughts of a child about the way it was treated in the home situation:

> If the child is treated badly in the house, it might bring the child to think about his parent and the wishing that if the parents were alive then she could be treated different. The child might go to bed thinking about her parents and that might make it to appear as a dream but it is just the child's thoughts of sadness.

Some children similarly indicated that their dreams were actually thoughts which they had at night: 'I would just be thinking about my father' (Martin). Second, such dreams were perceived as real dreams, mostly children explained their dreams in this way. Third, children's dreams were also suspected to be related to witchcraft, by which they meant supernatural causes of death and an active wishing the other ill. Helena experienced such dreams, and was not allowed to tell others about it. She noted:

> Sometimes I do not only dream about my father, I also dream about a tall person wearing a cap just standing at my bed looking at me. Because I sleep alone and the bed is big, I would dream of people sleeping on the same bed with me. I would then move to the edge of the bed because if I touch them they scratch me. I told my mother and she said I should not tell other people. She said that it might be witchcraft related, and the person I am telling my dream to might be the one who is doing that to me.

Possibly, Helena's dreams were considered witchcraft related, as Helena's father died of AIDS. Helena was told by her mother to keep silent about her father's cause of death, and her mother did not open up about it in interviews as well. Ashfort (2002) notes that the silences and stigma associated with HIV/AIDS make much more sense if witchcraft dimensions within communities in southern Africa are taken into account, as silence and discretion are the norm with cases of witchcraft (p. 135). He states that no-one wants to publicise the fact that they have been cursed, as this would not only be embarrassing, but also dangerous as it would inform the witch about the efforts being made to counteract his or her occult assault (*ibid.*). In the South African context, witchcraft 'typically means the manipulation by malicious individuals of powers inherent in persons, spiritual entities and substances to cause harm to others' (Ashfort, 2002, p. 126). Jealousy, or envy, is typically the motive of witchcraft, and the people affected are considered to be related to the perpetrators, such as lovers, relatives, neighbours, schoolmates and workmates (*ibid.*). Cases of premature death or untimely illness, including HIV/AIDS, are almost always attributed to the action of invisible forces, often described as witchcraft (*ibid.*).

A common remedy against children's nightmares about their deceased parents (within the Ndonga Ovambos) was to drink sand from the grave of the deceased parent, generally practiced within a few months after the parent had died. Other remedies included taking the child to the hospital, or to the traditional

healer, and it was believed to help when people who are taking care of the child would pray. A grandmother explained the use of sand taken from the parent's grave:

> There is a belief from the ancestors that if a child dreams a lot about his late parent, people would go and take the sand from the grave of the parent, put it in the water and the child drinks that water. The child would also be splashed over the face with the sand from the grave.

Possibly, this practice aimed to discontinue the connection with the dead. Dreams can be viewed as a way for children to continue a connection with the deceased parent (Silverman et al, 1992). Demmer (2007) similarly observed that in South Africa symbolic ties with the deceased were sustained through dreams.

3.3 RESEARCH FINDINGS PART 2: WAYS OF DEALING WITH LOSS AND GRIEF

The second part examines the ways grief is dealt with in northern Namibia: caregiver's advice to accept and forget the death of the parent, children's and adolescent's distinction between 'thinking about' and 'remembering' the parent, and factors that help children and adolescents to live with grief.

3.3.1 Caregivers' advice to accept and forget

The responses of caregivers to children's grief following the death of a parent consisted of an emphasis on acceptance and forgetting. Children were advised to accept the finality of death. They were told 'The person is gone', 'Death is a natural aspect of life', 'Death does not stop, people die', 'People are dying every day' and 'We are visitors on Earth and will be gone one day'. The emphasis on the finality of death among the Ovambo was also mentioned by the missionary Tönjes, who wrote in 1911 that the phrase 'all people are unavoidably headed towards death' was part of a common riddle (Tönjes, [1911] 1996). Caregivers reminded children of the role of God in order to help them accept parental loss and comfort them: 'The person is taken by God' and 'God is comforting you'. Also within the churches, an acceptance of death seemed to be emphasised. A staff member of the NGO Positive Vibes mentioned that the Lutheran and Born Again

Christian churches preached that people should not grieve over someone's death. Grieving would indicate a lack of faith, as the person was taken up by God. Moreover, caregivers told children that their individual situation was similar to that of a larger number of other children, as many had lost their parent. They were also advised to accept and adjust to their new life. Children were told that they still had their aunt, uncle or sister who would take care of them.

Forgetting about the death of a parent was commonly perceived by caregivers as an effective way for children to deal with parental loss, and they often encouraged children to forget their deceased parents. Caregivers described forgetting as 'not thinking a lot' about the death, and to 'not think it over and over'. By forgetting, the child would be least afflicted by the death, and the child would be able to focus on his or her new life. An aunt noted: 'Forgetting the late parents helps the child to go forward'. Caregivers had mixed opinions about whether children could easily forget about the death of a parent. Some argued it was easy for children to forget the parents, while others felt that a child would always know that his or her parent had died. However, although the child was not able to forget completely, the sadness related to the loss could disappear.

Children were perceived to recover faster from their parent's death when caregivers did not talk about the death of the parent, so that children were not constantly reminded of their death. Not talking about the deceased has been part of the ways death was dealt with. For instance, Nampala (2006) notes that in the past, it was common among the Ndonga that after a person had died, his or her name was not mentioned any more, as well as anything about the person; but was only referred to as 'the deceased' (p. 64). Caregivers generally considered it problematic and dangerous when a child could not easily let the death of its parent go. The child's concentration at school could be affected, and the child would not be productive later in life, as 'the thought about the late parent is damaging her'. Furthermore, not forgetting could have severe effects such as going mad, 'ending up on the psychiatric ward' or it could lead to the death of a child. A grandmother stated:

> It is better for the child to forget the face of the late parent and the things they used to do together because if the child keeps on remembering that, it may trouble the child a lot.

Children were sometimes even taken from the house where they had been living with their parent, and placed in the household of a relative in order to enhance

forgetting; this was similarly applied to adults. For instance, this measure was taken when a child mentioned the parent regularly. The house would evoke too many memories of the deceased, and moving to a household where the child had not been living together with its parent would help the child to forget. A mother explained why it was problematic when children were reminded a lot about their parent: 'In the mind of the child the person is still alive because of the imagination he or she has of the parent'. However, some caregivers expressed their concern that when the child was pressured to forget, the child could become withdrawn.

The treatment of a child in its foster household was commonly considered to influence the process of forgetting. This is in line with the findings of Hutchinson's study in Malawi (2011); orphans should be treated well in order to stimulate forgetting. One caregiver noted that the grieving of the child after the funeral depended on fair treatment between the orphaned child and non-orphaned children in the household, such as giving them a similar lunch box to take to school. Caregivers stated that when a child was still grieving after the normal mourning period, and could not forget the parent, it was likely that the child was treated badly. In the words of a grandmother:

> The child will only forget about the death of a parent when she is treated well, when she is not treated well she will not forget.

Some caregivers indicated they were thus treating the orphans in their household with care, because if orphans were treated badly, they would start thinking about their parents. Furthermore, others indicated they had taken over the role of the late parent, 'I am now the mother', in order to enhance forgetting.

3.3.2 Thinking about the parent

Orphans reported thinking about their deceased parents. This can also be defined as 'not being able to forget' about the parent. Thinking about parents was generally perceived as negative, emotional, and associated with the absence of the parent in the child's life. The word 'missing' *(kani)* was not used often in relation to a deceased parent, as this refers to the absence of living people in Oshiwambo. In a way, the concept *thinking about* bear a resemblance with the item "finding it painful to recall memories of the deceased" of the dimension 'complicated grief' (Melhem, Day, Shear, Day, Reynolds and Brent, 2004). Melhem et al (2004)

identified with the use of factor analysis two dimensions of grief responses in children; normal grief (items such as missing the deceased) and complicated grief.

The majority of the child orphans expressed to be thinking about their deceased parent. They generally thought about their parent when being treated badly by their caregiver or other people in the household. Children thought about how the parent could have helped them when they were not treated well, either by defending, comforting or protecting them. Children also reported to think about their parents when they needed material assistance, such as when their clothes were torn, and contemplated on the help their late parent could have provided. This relation between grief and social and economic insecurities is discussed in Chapter 5. Most children were 'feeling bad' when having these thoughts, and generally stated it was not good to have such thoughts as it would make them cry, stressed, or thin. Only a few children perceived thinking about their deceased parent as good.

Non-orphaned child participants who recently lost a close relative such as a grandmother or sister also reported to be thinking about the deceased. Their thinking about the person was not related to bad treatment but occurred randomly: 'When I am laying down' (Nile), 'Just when we are eating' (Frieda), 'When I remember her birthday' (Nothando). Children's thoughts about the person were generally memories about how the person had been: 'She used to tell us stories' and 'She used to treat me nicely'. Berthilde, a girl who stayed in a household where several relatives died within a short period of time, regularly thought about these deaths at night. This might also be related to the fact that her family suspected these deaths were the result of their house being cursed.

In contrast, the orphaned adolescents showed a more diversified picture of their thinking about their parents than the child orphans. Some adolescents thought about them often, but others indicated that their thinking had become less over the years, and a few never thought about their parents. Adolescents, who thought about their parents, did so – like the child orphans – when they were treated badly in their household, or when they needed financial assistance. For instance, Claudia recalled how her father had supported her with school materials; when her caregiver refused to buy her school materials, she thought about her father. For other adolescents, the general absence of having a parent in their lives stood central, such as not receiving love from their parents or not being

able to walk next to them. For instance, Justin related that he missed his parents when comparing himself to others:

> I always wished to stay with my father and mother like others. I think about how we could have been staying together with them. Children, who visit our house, sit next to their mothers. When others are talking about their mothers, or when I am shopping with my colleagues and they buy something for their mothers, then I think about my mother.

However, most adolescents were thinking less about their parent over the years. This was due to several reasons. Firstly, adolescents had stopped thinking about their parent when their home situation had improved. For instance, in 2010, Grace stayed with her grandmother who was treating her badly, which made her regularly think about her deceased parents. In the following years, after her grandmother had left the household, she did not think about her parents any more. Also Claudia thought less about her father after she had left her aunt's household who was mistreating her. Secondly, receiving information about the parent made adolescents think less about them. For instance, Hilma stated in 2010 that she was thinking about her father 'at times when I am treated badly or when I am bored. I keep asking myself why he had to die' and indicated that these thoughts make her sad. In the following years she did not think much about her father as much, because she had seen a picture of him. Thirdly, thinking less was also viewed as part of the forgetting process in dealing with loss. Lena, who lost her sister, thought about her sister a lot in the first year after her death. However, in the following year she did not think about her sister as much as she realised that 'everyone dies one day'. She suspected she would stop thinking about her sister at all in the future. She felt that not reminiscing about her sister was a good thing, as it had caused her a lot of thoughts, and it would stop her from dreaming about her sister as well. Grace similarly hoped to forget about her parents in the future, she noted: 'I pray for them, which helps me to forget about them'. Fourthly, some adolescents made a conscious decision to think less about their deceased parent, as they found it had negative effects on them. Alex related:

> When I was growing up I realised that my father was not around. If I saw someone with their father, I asked myself, why me? Now I don't like to think about things in the past, I throw them out of my mind.

Also, Samuel consciously stopped thinking as 'it cannot change the fact that my parents are gone, so I better do not care anymore'. Before, in 2010, Samuel had

been reminded a lot about his late parents and grandmother, who had been his main caregiver. He thought about them throughout the day and when people were shouting at him. Samuel related: 'I was suffering; I would think that if they had been alive, I would have new clothes'.

Other adolescents clearly stated they were not thinking about their parents as the person had been absent in their lives. Two girls, whose fathers had been not present in their lives when they were alive, indicated that they never thought about him because 'I don't know him'. Where the child orphans had clear ideas about what their late parent could have done for them, these children had realised that even when the parent had been alive, most likely the person would not have played a role in their lives.

3.3.3 Remembering the parent

Generally, a distinction was made between remembering a parent *(dhimbulukwa)* and thinking about a parent *(dhiladhila).* Where thinking was regarded as negative, remembering was often considered positive, associated with good memories about the parents and a commemoration of the person's life. One child summarised this, saying: 'It is not good to think about my mother, but it is good to remember her.'

Caregivers indicated that the deceased were mostly remembered by talking about the work the person had done, by reviving memories of the deceased, and by talking about the person's behaviour. This mostly happened after the initial sadness over the loss had lessened. Children and adolescents remembered their parents by praying for them, and reminiscing about them: 'You think in your heart about a person, and remember him that way' (Justin). Children also remembered their parents when other people talked about their parent.

Photos were the main items for children to remember their parents. Nearly half of the children had access to a photo, which belonged to the child, or to its caregiver. Some children looked at the pictures on a daily basis, and had positive thoughts when looking at the pictures such as 'If he was alive I would love him' (Hango). Festus, who had not known his father when he was alive, could form an image of him through his photo (Figure 3-9). Others looked only occasionally at the photos, or only when they missed their parent. Looking at the

pictures also evoked negative feelings: 'Every time I look at him, I wish he was alive' (Martin). Several caregivers discouraged this way of remembering. Helena, an orphaned girl, noted that she was beaten when she cried over her father's photo: 'They would say I am crying over useless things'. Children who did not own a picture were worried that they would cry or be scared when seeing a picture of their deceased parent. Others, however, imagined that having a picture would help them when they were missing their parent: 'I could look at the picture when I miss him and say that my father looked handsome' (Esther). Funeral programs were also a method used to remember their parent. Children who experienced a recent loss were often reminded of the deceased by their clothes, as the deceased's clothes were worn by relatives. Brewer and Sparkes (2011) argue that looking at pictures might be a way for bereaved adolescents to establish an ongoing relationship with the dead parent (p. 287). They conducted an ethnographic study in the United Kingdom, wherein 13 parentally bereaved young people participated, who sought support from a childhood bereavement centre. Next to looking at pictures, the participants also listened to tape recordings of the parent's voice or sought advice from the deceased by having internal conversations with them in order to establish such a relationship (*ibid.*). Also Rosenblatt (2006) stressed the meaning of personal reminders (for instance photographs and personal possessions of the deceased) for the survivors, as such reminders often define feelings and personalize the significant other and their relationship (p. 103).

Visiting and cleaning the grave of the parents were the main activities to recall deceased parents. Graves were mostly visited when the parent was buried close by; half of the orphans had never visited their parent's grave as they were buried in other villages. The graves were generally cleaned on Easter, Christmas or on the dying date of the deceased. Some children felt uncomfortable visiting the graves as it reminded them about the absence of the parents in their life, and about how their parents could have made them happy. However, others had positive experiences: 'It feels good when I find the graves of my parents cleaned like the other graves' (Justin). Other remembrance activities were rare. One family organised a remembrance day for a deceased grandmother every year, and the birthday of a deceased father was commemorated by wearing the t-shirts which were worn at the funeral.

Orphaned children and adolescents who had known their parent had memories about their parent's caring for them, such as washing their clothes (Figure 3-10) and cooking for them, taking them to the shops, but also paying school fees for them. Grace remembered: 'My parents prepared food for us in the morning before going to school, but that does not happen anymore'. Others recalled the things they did together with their parent such as herding cattle or walking together, or their parents' love for them. Children who had not been staying with their late parent remembered the visits to or from their parent, and outings they made together.

Figure 3-9: Image of how father had looked (Festus)

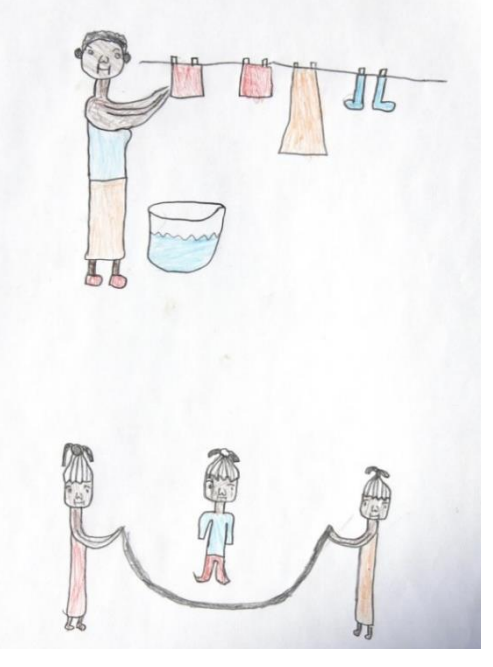

Figure 3-10: Memory of mother doing the laundry (Liezel)

3.3.4 Factors that help children and adolescents to live with grief

Brewer et al. (2011) argue that there is still a lot to learn about how young people navigate through difficulties relating to parental loss. Understanding some of the factors that young people identify as helping them to cope with their grief is important, as this may provide insights for childhood bereavement services (*ibid*.).

My study explored children's and adolescents' experiences of coping with parental death from their own viewpoint. According to most children, playing with others, for instance soccer, and playing individually, such as forming mud cows, was helpful. Carrying out chores, such as herding cattle or collecting firewood, were also mentioned as activities that helped children to take their mind of their sorrow. Children further indicated that they would read a book, or sleep when they were feeling sad about their parent's death. Additionally, nice events were similarly perceived as supportive: 'When I am told to go and buy sweets' and 'When someone says that we will visit my father'. One child noted that he informed his grandmother when he was feeling sad.

Adolescents emphasised the importance of friendships and other social support in order to make sense of their experience of bereavement, and to become happy when they were feeling sad. Girls especially mentioned that meeting with parentally bereaved friends was valuable for them. Hilma expressed how she and her friends would 'encourage' each other and advise each other: 'We tell each other not to keep thinking about our late parents because that is how life is'. Lena perceived it as helpful to receive advice from her sister when she was feeling sad about the death of their other sister: 'She would tell me it does not help to feel sad'. Adolescents also contacted friends when experiencing sorrow about their loss, or when they 'started to think' about their parent. Texting friends, meeting with them, and telling each other 'funny stories' was seen as comforting. Justin mentioned that his grandmother would tell him stories about how people lived in the past, which helped him to forget his unhappiness.

Religion was also recognised by adolescents as a source of strength to deal with bereavement. They expressed that going to church, praying, reading the bible, and singing gospel songs helped them. Hilma expressed: 'I would sing and my sisters would join in and I would be happy. We sing gospel songs'. Studies on AIDS-related loss additionally point to the importance of spirituality in coping with the death of a loved one. Demmer (2007) notes that in South Africa many of the bereaved individuals he spoke to gained meaning from their experiences and received comfort through their spiritual faith. In a study on African-American grandmothers who took care of their grandchildren after their child had died of AIDS, the women likewise mentioned that their religious and spiritual faith helped them to cope with the losses they had experienced (Winston, 2006). Their spiritual relationship with God was viewed as a source of strength to deal with

difficulties and coping with a loss to a stigmatising disease (p. 39). Other factors that helped the adolescents in my study to 'not think a lot' about the death included sleeping, 'when someone buys me something nice', studying, listening to the radio, playing soccer and writing in a diary. For example, Alex commented:

> I often do something because you may end up lying there thinking about those things. I can even go and play soccer or go and sleep. Anything; I can chat with a friend or I can go to my aunt's house and watch TV. Just things to cheer me up and then I would forget.

Some adolescents also spoke of how their way of thinking provided a beneficial way of coping with parental death. Examples included: 'I would think: there are people that can help me' (Alex) and 'I often think that I cannot change it: why should I be unhappy when the death already happened' (Brigita). Meke valued having 'good self-esteem' in dealing with parental loss:

> I do not want to feel pity for myself, not always reminding myself that I am an orphan but I want to be like other children who have parents.

When comparing these factors with the UK study of Brewer et al. (2011) on how bereaved adolescents cope with parental loss and make sense of their grief, various coping factors are similar such as sport, music, the importance of social support and friendship in the cultivation of happiness after the death of a parent, and the role of fun and laughter. Yet, other factors appear more typical for the Namibian context, such as carrying out chores, sleeping, receiving gifts, and in line with the adult's advice on handling loss: accepting and not thinking about the parents.

3.4 DISCUSSION

The findings of this chapter demonstrate that childhood grief was generally recognised by adults as an experience which does not last long. Such perceptions can be considered as 'disenfranchised grief'; this term refers to grief that is not openly acknowledged, socially sanctioned or publicly mourned (Doka, 1999). The exclusion of the griever, such as children and elderly, is one of the aspects causing grief to be disenfranchised (*ibid.*); thus, it is not acknowledged that certain groups are capable of grieving. Blin and Jonas-Simpson (2018) argue that due to children's limited verbal capacity and their differences in reacting to loss, their responses

may be misconstrued (p. 36). Children's grief has a tendency to be more intermittent and showing different overt behaviour than that of adults (Siegel et al., 1994, p. S67; Tremblay et al., 1998, p. 425).

Children and adolescents were only allowed to openly show grief until the funeral. Similar to other African grief studies (Nordanger, 2007; Demmer, 2007), this study found that the health effects of crying were an important reason to stimulate crying during the mourning period, but restrict it afterwards as crying could then result in illness. Besides this, the crying of children over the loss of their parents would indicate they are not treated well in their foster household. Children were urged by their caregivers to accept the death of their parent and 'forget' about their deceased parent. Such a pattern of dealing with loss seems to leave children and adolescents little room to express and share their grief in the period after the funeral.

Dreams about their deceased parent(s) were often part of children's and adolescents' bereavement experience. In exploring the relation between culture and disturbing dreams, Hollan (2009) states that one should not only consider 'how culture affects the interpretation of disturbing dreams, but also how it might affect their formation and experiencing more directly' (p. 314). Dreams can be viewed as a way for children to continue a connection with the deceased parent (Silverman et al, 1992). Brewer et al. (2011) argue that culture will be influential in determining the usefulness and meaning of such continuing bonds for children whose parents died (p. 289). For instance, variations are found between Chinese respondents where higher levels of continuing bonds are related to better adjustment (Lalande and Bonnano, 2006), and North American respondents where higher levels of continuing bonds are associated with higher levels of distress (Neimeyer, Baldwin & Gillies, 2006). In my study, dreams about the deceased parents were often perceived as distressing as well. Furthermore, such dreams were generally related to the notion of thinking about the parent. One could argue that in a situation wherein forgetting of the parent is emphasised, and showing grief is not allowed, dreaming might be a method for children to express or deal with their grief. Such issues should be studied further to enhance our cross-cultural understanding of children's dreams as a response to parental death.

This chapter further shows that the ways of informing and involving children in death-related issues are subject to change. Whereas in the past children were shielded from death, most children are now informed about the death of

their parent and attended their funeral. Nonetheless, this change was not viewed as a positive development by all adult participants, as attending funerals would prevent children from 'forgetting' about the deceased and create emotional distress. On the basis of these arguments, children in other parts of southern Africa are routinely kept away from funerals. A study in Botswana shows that children are still excluded from their parent's funeral as they would be traumatised by the death (Daniel, 2005, p. 196). However, other caregivers perceived the attendance of funerals as helpful for children to accept the death of their parent. Moreover, some of them questioned the belief that children should not cry over the loss of their parent. Such changes could indicate an increased awareness for the ways children experience death and loss.

The importance of, and interrelation between, forgetting and memory in coping with loss and grief which is found in my study, is consistent with other grief studies in non-Western settings (Hemer, 2010; Hutchinson, 2007; Battaglia, 1992; Weiss, 1997). Hemer's (2010) observation that forgetting is seen to resolve worry over a death applies to the findings of my study: children would be able to recover faster from the loss by forgetting the parent. Weiss's (1997) argument that forgetting is valued as this makes memory possible appears to be relevant here. The 'real' deceased person and corresponding sadness should be forgotten in order to commemorate the dead person; while at the same time the dead were remembered by sharing stories, and mentioning the work they had done. Furthermore, adolescents wished to forget about their deceased parents, more so than the child participants, which might be an indication of the socialisation process of grief experiences (see Noret, 2012). Hemer (2010) writes about memory management, and Hutchinson (2007) similarly describes that forgetting is seen as an active process in Malawi. In my study, forgetting was also actively encouraged by destroying possessions of the deceased, and, at times, by removing the child from the household where it had lived with the parent in cases when the child mentioned the deceased parent regularly.

The emphasis on accepting the death of the parent, and forgetting about the parent as a way of dealing with loss is in line with a 'restoration-oriented' method towards coping with death (Stroebe et al., 1998). Some characteristics of 'restoration orientation' include attending to new life opportunities, the avoidance of grief, and forming new relationships (*ibid.*). Such factors were mentioned in my study as important issues that would help children to deal with death: children

should not think about their parent, but focus on their new life situation and their new caregiver. This focus on restoration may also be related to a characteristic of HIV-related bereavement: the fact that many children lose more than one family member to AIDS (Siegel et al., 1994). Some children in this study had not only lost parents, but also siblings, aunts and others due to AIDS. Possibly, caregivers perceive acceptance and restoration as the best way to deal with such difficult life events. Orphans themselves oscillated between the two ways of dealing with loss (focusing on their loss on the one hand, and distracting themselves with other activities on the other), although the latter was dominant. For instance, they remembered their parents by looking at their photo, but at the same time they distracted themselves and tried to forget about the loss. Brewer et al. (2011) similarly found that the parentally bereaved adolescents in their UK study oscillated between these two ways of dealing with loss.

Generally, the influence of HIV/AIDS on the grief experiences of children was not apparent in my study. This may be due to the fact that a large proportion of the orphans did not know the cause of their parent's death or they were not allowed, or did not want to, talk about it as will be discussed in the next chapter. Besides, only a few had cared for their ill parent, so this aspect of AIDS-related loss – witnessing the decay of the parent (Wood et al., 2006) – did not seem to be a main factor. Furthermore, HIV-positive orphans in this study were unaware of their own HIV-positive status, or kept their status hidden, therefore this factor of AIDS-related bereavement - the intertwinement of HIV-positive children's questions about their own health and grief (Demmer, 2009) - was also not mentioned by the children in this study. However, some issues could be identified whereby HIV and AIDS possibly influenced childhood grief. Firstly, during interviews, a few remaining mothers whose husbands had died of AIDS, spoke of the anger they felt towards their husband for their extra-marital affairs, and about leaving them behind to the care for their children. During the research it also turned out that some mothers were infected with HIV through their husbands. Such anger may affect a mother's response towards their children's grief over their father's death. For instance, as is written in this chapter, a girl was beaten by her mother when she cried over the photo of her late father. Secondly, multiple losses due to AIDS can also bring about a different way of dealing with loss. For instance, some adolescents mentioned that they and their parentally bereaved peers 'encouraged' each other to move on with their lives; this might be

increasingly relevant when experiencing multiple losses in the family. Thirdly, contexts of fosterage may impact children's ways of dealing with loss and grief. Due to multiple AIDS-related deaths in a family, orphans are often taken care of by distant relatives. This study shows that in these households, there was often little to no attention on the emotional impacts of parental loss. The following chapters also show examples of how HIV/AIDS influences, in diverse and often indirect ways, childhood grief in northern Namibia.

4

Obstacles in caregiver – child communication on parental loss

4.1 INTRODUCTION

Grieving and bereavement are not just individual, psychological processes, as was argued in the previous chapter. They are manifested and negotiated through communication within social contexts, of which the family is probably the most important (Bosticco and Thomson, 2005). Bosticco et al. (2005) thus stress the central role of communication in family units and subunits in the grieving process (p. 273). They underline the need for research that examines the interrelation between communication, grief and bereavement, whereby procedures incorporating discourse within bereaved families should be looked into in order to 'more adequately understand how families make sense out of loss and renegotiate family roles, tasks, and interaction patterns' (*ibid.*). In particular, ethnographic research on grieving families would generate crucial insights into family communication during bereavement (Bosticco et al., 2005, p. 274).

This chapter explores communicative processes in relation to parental loss and grief in families in northern Namibia. It examines the role of such processes in childhood grieving and bereavement by looking at how the late parents are discussed within households – between adult caregivers, children and adolescents – in the years after the death of a parent. The previous chapter showed that when it comes to dealing with loss and bereavement in the Ovambo society, a strong emphasis is placed on forgetting and accepting. Within such an approach, it is expected that caregivers communicate minimally with children and adolescents about their late parents. Studies that have addressed the issue of family communication in relation to parental loss in a southern African context observed both silence and secrecy, caused by HIV-related stigma, parenting styles, and taboos on talking about death with children (Wood, Chase & Aggleton, 2006; Daniel, Apila, Bjørgo & Lie, 2007; Van der Heijden & Swartz, 2010).

Several characteristics of adult-child communication on parental loss can be distinguished, such as the sharing of memories about the late parent, providing information about the late parent, and addressing the emotional impact of the loss on the child. This chapter mainly focuses on information providing and memory sharing. The main questions examined are: (i) What information about the late

parent is desired by children and adolescents and provided by them to caregivers, and (ii) In the case of 'silence,' what are the reasons for this limited communication? The following sections examine literature on the communication of loss. This includes how silence can be interpreted, presenting an overview of studies that have looked into intergenerational communication in various sub-Saharan African countries. It also pays attention to various reasons for limited adult-child communication on parental loss, such as taboos on death, parenting styles, and HIV-related stigma, with special attention on HIV nondisclosure concerning the parent's cause of death. The findings section examines what types of information about the late parents was desired by, and given to, orphans. It also presents a model on the various reasons that obstruct intergenerational communication on parental death in northern Namibia.

4.1.1 Communication on loss and death

Communication within families on loss

Family communication on loss, and especially the sharing of memories about the deceased, is addressed in studies on loss and bereavement that look at grief as a social phenomenon, taking place within an interpersonal context of friends, family and culture (Rosenblatt, 2001; Walter, 1996). For instance, Walter (1996) argues that survivors, together with other people who have known the deceased, construct a story that places the dead within their lives. He writes: 'The purpose of grief is therefore the construction of a durable biography that enables the living to integrate the memory of the dead into their ongoing lives; the process by which this is achieved is principally conversation with others who knew the deceased' (p. 7). Furthermore, Neimeyer (1999) states that a major loss has implications for the bereaved individual's sense of identity (p. 67), and that such loss can undermine the coherence of the self-narrative (Neimeyer, Burke, Mackay & Van Dyke Stringer, 2010, p. 74). Thus, as Baddeley and Singer (2010) note, loss can be viewed as a disruption to the narrative identity. They write: 'When a family member dies, each surviving family member and the family on the whole must inevitably confront the respective questions of "Who am I" and "What is my family?" now that this critical member of their family is gone' (p. 200). They note that narrative bereavement theorists such as Walter (1996) and Neimeyer (2001),

argue that 'individuals turn to (co)recalling and sharing stories about the loved one and the loss in order to repair and stabilise their fragile sense of identity and to reaffirm their understanding of roles and relationships within the family structure' (*ibid.*).

Communication on loss is also valued in studies that have looked at children's adaption after the death of a parent. Attentive and sensitive parenting practices during caregiver-child communication are associated with less psychopathology following the death (Shapiro, Howell & Kaplow, 2014). Shapiro et al (2014) suggest in their US study that mother-child communication is an important factor in determining children's grief reactions following the death of a father; sensitive and engaged communication of mothers is associated with lower levels of maladaptive grief and depressive symptoms of children. A study on north-American parentally bereaved children found likewise that supportive caregiver communication and positive parental reinforcement was inversely associated with PTSS (Howell et al., 2016). The authors argue that 'parents' supportive communication may also provide their children with empathy and social support regarding the death and model appropriate emotional expression, both of which may promote adaptive coping' (p. 161). In their review of western studies, Siegel and Gorey (1994) similarly found that bereaved children showed a healthier adaptation to their parent's death when the family communicated, made decisions together and openly shared information, whereas children with problematic grief reactions experienced an absence of open communication (p. s68). Children who are prevented from asking questions about a parent's illness or death may develop misconceptions, which can be a source of psychological distress (p. S68).

Tremblay and Israel (1998) also note, based on a review of Western studies, that being able to talk freely about the late parent with the surviving parent is one of the factors that appeared crucial in children's adaption to parental loss (p. 431). A study on school age children in which a parent had died of cancer likewise found that openness in communication about the death helped children to cope with death (Raveis, Siegel & Karus, 1999). The child's perception of the surviving parent's level of openness in parental communication significantly correlated with lower levels of depressive symptoms and state anxiety in bereaved children (p. 165). In South Africa, caregiver-child communication in contexts of disadvantage and adversity was found to have a protective role; more frequent

conversations with caregivers about personal problems and challenges could be responsible for orphans (and non-orphans) lower anxiety and depression scores (Govender, Reardon, Quiland & George, 2014).

Silence as a response to loss

How should silence as a response to loss be understood? Baddeley et al. (2010) claim that silence can be perceived as the opposite of sharing autobiographical memories in the face of grief (p. 198). They thus speak of 'unspoken memory' – the withholding of social shared autobiographical memories about the loss and the departed family member, in an individual griever's narrative identity, as well as in the larger family narrative (*ibid*.). Silence in relation to memories about the deceased resembles a 'restoration-orientated' pattern to adjustment in the Dual Process Model of Coping with Loss (Stroebe & Schut, 1998), whereas telling stories about loss fits into loss-orientated coping. Bereaved people generally oscillate between the two processes (*ibid.*). Silence about one's memories of the deceased might be important to allow room for restoration-orientated coping activities, Baddeley et al. argue (2010, p. 201).

In the literature, several reasons for silence are highlighted. Firstly, protection from sadness seems a crucial motivation to not talk about loss and death. For instance, Silverman, Weiner and Elad (1995) reported in their study on surviving parent-child communication amongst bereaved Israeli families that some of the surviving parents believed that they must shield children from the sadness and the pain associated with the loss by avoiding discussing the child's feelings about the loss (p. 275). DeMaso, Meyer & Beasley (1997) also note, based on years of experience in consulting bereaved American parents who had lost a child, that parents often wish to 'spare' the remaining children and themselves the emotional burden of retelling the story (p. 1299). Kaplow, Lyne, Pynoos, Cohen & Lieberman (2012) note that in many bereaved families it is common for surviving parents to avoid parent-child discussions regarding a death, as they doubt the ability of children to understand the consequences of such experiences.

Secondly, not talking about loss also seemed to be caused by an inability to talk due to a strong sense of loss. In a study on widowed families in the United States, Silverman and Silverman (1979) described widows and widowers who found it difficult to talk to family and significant others due to their overwhelming

sense of loss, and the discrepancy between their emotional desires and the reality of the death. However, as their sense of loss diminishes, they seemed to be able to communicate more easily. Delaplace (2010) explains in his account on the role of silence in contemporary mourning practices in rural Mongolia that silence of the bereaved person's next of kin may come as a response to the expression of extreme grief by the bereaved person. This silence suggests the absence of an attempt of sense-making; it acknowledges that some losses do not make sense, and that they should not be constructed as meaningful events for the bereaved (*ibid.*). Delaplace writes: 'Such a display of intense grief seems to leave no other option for his close kin than to 'give up on words' and meaning altogether, there being nothing left to offer the mourner but silent affection – perhaps the rawest material of human interaction' (p. 530).

Thirdly, keeping secrets appears to be a reason for limited communication on loss. In his article on family secrets, Karpel (1980) identifies secrecy surrounding a death as a communication practice that withholds information from bereaved individuals who might need it during their grieving process. It affects relationships, and leads to distrust and anxiety. Karpel defines a secret as 'information that is either withheld or differentially shared between or among people' (p. 295). Thus, peoples' choices to opt for silence in relation to loss might be based on various reasons; additional justifications for silence in the Namibian context are mentioned below.

Silence in African caregiver-child communication on loss and death

In this section, the specific context of communication on death within sub-Saharan Africa is discussed. Studies that have explored intergenerational communication in relation to parental AIDS-related illness and death in sub-Saharan Africa, have found silence and secrecy. In Zimbabwe, adults – the sick parent or caregivers following parental loss – often did not inform teenagers about the parental illness and death, while many orphaned adolescents desired to be spoken to more openly (Wood et al., 2006). In the case of younger children, secrecy was usually even more apparent as children were not told that the parent had died, but had instead gone away (*ibid.*). Orphaned children in Uganda similarly received little information about the illness and death of their deceased parents (Daniel et al., 2007). In South Africa, Van der Heijden et al. (2010) found that death was not talked about openly

with children, nor were memories of the deceased elicited by adults. The child participants of this study, who took part in a program which provided bereavement support, indicated it had been the first time they were allowed to speak of the loss of loved one (*ibid.*).

Such silence and secrecy may have negative consequences for bereaved children and adolescents. According to Van der Heijden et al. (2010), silence surrounding issues such as AIDS-related parental illness and death may detrimentally impact the grieving process and wellbeing of children and adolescents. Daniel et al. (2007) state that silence carries an element of denial which may be harmful for children, and may increase their general vulnerability. Secrecy about the illness and the cause of death of parents can leave young people with feelings of resentment, broken trust and anger (Wood et al., 2006). Wood et al. (2006) also describe cases where orphaned young people suspected the nature of their parent's illness but were not openly told, and children who were not informed about the death of their parent but found out from other sources. This secretive approach was perceived as hurtful (*ibid*.).

Silence may also lead to diminished emotional support from adults in the grieving process. Howard, Matinhure, McCurdy and Johnson (2006) note in their study on Zimbabwean orphans that many orphans, especially double orphans, indicated that they had no-one to talk to about their deceased parents, and conclude that children are often on their own when it comes to the task of mourning. Demmer and Rothschild (2011) add, based on their study with South African adolescents whose siblings had died of AIDS, that these adolescents similarly received inadequate emotional support from any source both before and after the siblings' death. Adults in the study of Wood et al. (2006) were also often found to be ill-equipped to identify and manage orphaned children's distress positively.

4.1.2 Reasons for silence in African caregiver-child communication on death

Several causes for limited communication on death and loss have been listed in the previous section. In this section, important reasons for limited adult-child communication on death in the sub-Saharan African setting are discussed.

Taboos around death and sex

Taboos regarding talking to children about death and sex hamper the adult's abilities to discuss these issues with children (Daniel et al., 2007; Van der Heijden et al., 2010). Such taboos might influence caregiver-child communication on the late parent, especially when the parent died of HIV/AIDS, due to the sexual transmission of HIV. Historically, sex education and teaching about sexual relationships took place during initiation rites, instead of by parents (Wieringa, 2001). For instance, sex education within the Ovambo was often carried out during initiation by elders or other designated individuals (Wieringa, 2002). However, although historical practices such as initiations have eroded, the correlated taboos of parents not discussing sexual issues with their children still exist in many sub-Saharan African countries (Wieringa, 2001). Due to socio-economic changes that have altered family structures and social norms, these traditional systems of communication have been uprooted, leaving a gap in children's sex education (Poulsen et al., 2010). The consequences of the HIV epidemic have motivated parents to communicate with their children about sexual and reproductive health, but are, amongst other factors, limited by cultural barriers (Wamoyi, Fenwick, Urassa, Zabas & Stones, 2010).

In the southern African context, death is often surrounded with taboos. For instance, in the Zulu cultural setting it is inappropriate to speak directly of death, as the naming of the passing of life would bring misfortune to the family (Ntsimane, 2005). As has been noted in the preceding chapter, previously amongst the Ovambo, the name of the deceased was not mentioned, as well as anything about the person (Nampala, 2006). Death is often believed to be an inappropriate topic for children as well (Wood et al., 2006, p. 1925). In some South African cultures, children are not allowed to mention the name of a person who has recently died, as the speaking of anything connected to death is considered distasteful and ill-mannered (Mdleleni-Bookhalone, Schoeman & Van der Merwe, 2004).

Parenting styles

Notions of adult's authority and power in relation to children could also play a role in limited intergenerational discussion. For instance, research from Botswana showed that death was not often discussed with children as they were considered

too young to understand (Daniel, 2005a). As Christiansen, Utas and Vigh (2006) reflected on adult-child relations: 'The movement from childhood to adulthood is a movement not just between developmental positions, but between notions of power, authority and social worth' (p. 12). For instance, studies which look into parent-child communication on sexuality and HIV in sub-Saharan Africa report on the adult's power and authority (Bastien, Kujula & Muhwezi, 2011). Bastien et al. (2011) found in their review of such studies that discussions tended to be authoritarian and uni-directional.

Silence by children is valued in various sub-Saharan African settings. In an early study on child language socialisation in western Kenya, Harkness and Super (1977) already concluded that the silence of children, when they are in the presence of older or high status people, is considered a communicative competence. Abebe (2009) also notes that in rural Ethiopia, being 'vocal' is often in conflict with the cultural competencies of a 'good' child, namely diligence, respectfulness and politeness. Witter and Were (2004) argue that in Uganda, children do not often partake in family discussions and are not considered to have important views. In the Zulu cultural setting, children are told not to ask their parents questions, as addressing adults without being prompted is seen as a lack of respect (Denis, 2005). This is voiced in the expression: 'It is in our blood that children do not ask questions' (Denis, 2009, p. 7). When orphans grow up in households where Zulu customary respect (*ukuhlonipha)* is practiced, children should be silent in family matters (*ibid.*). Thus, rules of respect in family structures may limit communication across generation.

HIV-related stigma

Moreover, silence between children and adults is often intensified due to the stigma surrounding AIDS-related deaths (Daniel et al., 2007; Van der Heijden et al., 2010). Feelings of avoidance, shame, stigma, fear and guilt in relation to AIDS-related deaths may also shape children's expressions of grief (Richter, 2004). Besides this, as Demmer (2007, p. 826) found in South Africa, stigma may impact the ability of bereaved individuals to receive support from family members or others because AIDS as the cause of death is often kept a secret. Such situations are in line with 'disenfranchised grief' (Doka, 1999). Doka (1999) argues that when

people are isolated in bereavement, it might be more difficult to mourn and reactions are often complicated (p. 37).

Since the emergence of the HIV/AIDS epidemic, stigma has been recognised as a major barrier to effective management. Goffman was a pioneer in exploring the relationship of stigma to illnesses. Goffman (1963) defined stigma as 'an attribute that is significantly discrediting, which in the eyes of society, serves to reduce the person who possesses it' (p. 13). Already in 1987, Jonathan Mann, the former Director of the World Health Organisation's global programme on AIDS, named stigma the 'epidemic of social, cultural, economic and political responses to AIDS which is as central to the global challenge of AIDS itself' (Mann, 1987, p. 1). More than twenty years later, Ban Ki-moon, UN Secretary General, still identified stigma as 'the silent killer of AIDS' (Campbell, Skovdal, Mupambireyi & Gregson, 2010, p. 976).

Many studies attest to the impact of stigma on HIV. Stigmatisation is found to be associated with a range of emotional problems (such as stress, despair and depression), social exclusion, and lower levels of emotional and social support; stigmatisation may also negatively impact early diagnosis, medication adherence, accessing and retaining health care services, and the quality of health care received by people living with HIV and AIDS (PLWHA) (for a meta-analysis, see Logie & Gadalla, 2009, p. 274). According to the UNAIDS Gap Report, a substantial proportion of people living with HIV are being denied health services, employment, or experiencing physical assault because of HIV stigmatisation (UNAIDS, 2014). From a public health perspective, HIV-related stigma may cause new infections, as it has been associated with lower levels of HIV testing and knowledge of risk reduction (Leta, Sandøy & Fylkesnes, 2012; Turan et al., 2011).

In the past, the association with death was an important reason for HIV-related stigma (Niehaus, 2007). With the increasing access to Antiretroviral Therapy (ART), and thus a decrease in AIDS-related deaths, the question emerges as to whether this has led to a decline in the manifestations of HIV-related stigma. However, the decline in stigma in the southern African region has been limited (Gilbert, 2016). For instance, levels of perceived stigma amongst patients receiving ART in KwaZulu-Natal remained high (Peltzer & Ramlagan, 2011); and stigma forms a barrier for successful prevention of mother-to-child HIV transmission (Turan, Nyblade & Monfiston, 2012). Similarly, Chan and Tsai (2016, p. 558) conclude on the basis of a review that concomitant with ART scale-up in sub-

Saharan Africa, anticipated stigma in the general population increased despite a decrease in social distancing towards people living with HIV and AIDS (PLWHA).

How does stigma work? A large part of the literature on stigma that has used Goffman's framework in relation to HIV and AIDS, has adopted an individualistic approach by understanding stigma as an isolated phenomenon, or as the expression of individual attitudes (Parker & Aggleton, 2003). However, authors such as Parker et al. (2003) and Link and Phelan (2014) argue for a structural focus on stigma, with attention on the broader notions of power and domination, as it causes groups to be devalued or to feel superior to others. In order to explore the relationship between stigma and disclosure of HIV/AIDS as the parental cause of death, the conceptual model of HIV/AIDS stigma developed by Holzemer et al. (2007) is relevant. This model is based on reports from PLWHA and nurses from five African countries (Lesotho, Malawi, South Africa, Swaziland and Tanzania) (*ibid.*). In Holzemer et al. (2007)'s model, individual elements of stigma as a process (see Figure 4-1) take place within contexts which form the manifestations of stigma, including the healthcare system, environment and agents. The stigma process can be triggered or activated by any action that allows people to label themselves or others as HIV positive, such as HIV disclosure. Triggers lead to stigmatising behaviours that may harm, isolate, exclude or classify the person negatively (Holzemer et al., 2007). For instance, in a Zambian study, stigma behaviours such as gossip, verbal abuse and name-calling occurred commonly, whereby blame was assigned to people with HIV/AIDS, and assumptions were made about their past sexual history (Bond, Chase & Aggleton, 2002).

In the model, three types of stigma are identified, including associated stigma. Associated stigma, also called courtesy stigma, or stigma-by-association, can be traced back to Goffman who suggested that stigmas not only affect the individuals bearing them, but also those who are closely associated with these stigmatised individuals and groups (Philips, Benoit, Hallgrimsdottir & Vallance, 2012). Stigma outcomes are the consequences of shame as experienced by the stigmatised individual, whereby 'poorer health' includes both physical and mental health (Holzemer et al., 2007). Following this model, disclosing HIV as the cause of death of the late parent to a child could thus lead to associated stigma amongst their children, potentially causing poorer (mental) health in the children.

In the following section, a closer look is taken at the complex reasons, including stigma, that lead to disclosure or nondisclosure of the HIV status of late parents.

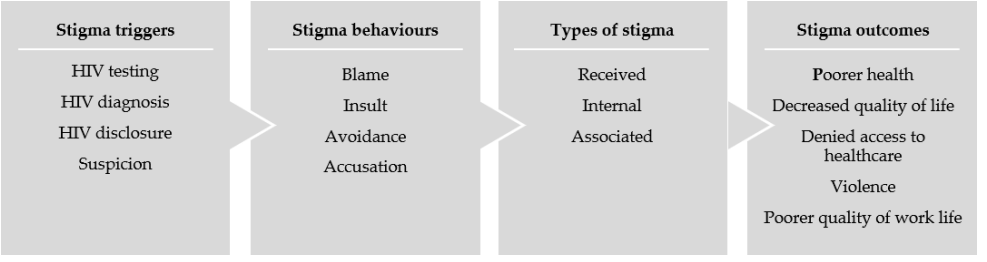

Figure 4-1: The stigma process (Holzemer et al, 2007)

Nondisclosure of HIV as the parental cause of death to children

A further reason that may limit communication about the death of a parent with children is that caregivers might be reserved in talking about HIV as the cause of parent's cause of death. Although few studies were conducted on whether orphaned children are informed about HIV/AIDS as the cause of death of their parent, parental HIV disclosure to children – thus, parents disclosing their own HIV status to their children – has been more widely researched. Exploring empirical literature on the latter could shed light on reasons why caregivers talk or keep silent about the HIV infection of the late parent towards children in their care.

Qiao, Li and Stanton (2011) conclude from their systematic review of global literature on parental HIV disclosure that a relatively low disclosure rate is found worldwide. In South Africa, a children's awareness rate (the proportion of children who knew the parental HIV status) was 44% (Palin et al., 2008). In Botswana, a children's awareness rate ranging between 29% and 33% was found, with the range caused by additional children guessing the parental HIV status (Nam et al., 2009). Most studies in the US showed that the increasing age of children was correlated to increasing parental HIV disclosure (Qiao et al., 2011). The age at which children were told about the parental HIV infection varied from 6-10 years in the US; whereas in non-Western countries parents generally waited until children reached early adolescence (12-14 years) or even adulthood (18 years or older) (Qiao et al.,2011). For instance, in Uganda the average age of the children at disclosure was 18 years (Rwemisisi, Wolff, Coutinho, Grosskurth & Whitworth,

2008). Various reasons were found for HIV-infected parents' decisions regarding disclosure and non-disclosure of their status to their children. Qiao et al. (2011) distinguished three main reasons in favour for parental disclosure in the global literature: parental needs, parenting practices and the consideration of children's rights and practices. In a US study on maternal HIV disclosure, these categories were found as well; mothers wanted to educate their children about HIV, wanted to be honest with their children, wished their children to hear it from them instead of from other sources, and wanted their children to know before they became very ill (Schrimshaw & Siegel, 2002). A qualitative study in Canada suggested that parenting styles influenced disclosure decisions: practices focusing on protecting children's innocence tended to shield children from knowing the HIV positive status of the parent, while practices aimed at stimulating children's autonomy encouraged disclosure (Dematteo et al., 2002).

The main reasons for non-disclosure found in the global literature included parent's concerns about their children's developmental level, their possible reactions to disclosure and the negative consequences of disclosure (Qiao et al., 2011). For instance, Schrimshaw et al. (2002) found in their US study that children would be too young or immature to understand, it would be too much of an emotional burden for the children, and that mothers did not want their children to experience rejection as other children might not want to play with them as a result of stigmatisation. Other studies found additional concerns, such as that disclosure would lead to problems in school performance (Thomas, Nyamathi & Swaminathan, 2009, in Southern India) and some parents living with HIV were afraid of losing respect from their children (Murphy, Steers & Dello Stritto, 2001, in Los Angeles County). In South Africa, the most common reasons for maternal non-disclosure were that the child would not be able to keep the diagnosis a secret; the mother did not feel ready to disclose; or mothers were concerned that the child would experience depression and anxiety (Palin et al., 2008). Barriers towards non-disclosure found in Uganda similarly included that children would be too young to understand what HIV infection means and fears of secondary disclosure (Osingada, Okuga, Nabirye, Sewamkambo & Nakanjako, 2017).

4.2 RESEARCH FINDINGS

After having discussed insights from the literature on communication and silence in the grief process, this section describes my own findings on caregiver-child communication about parental loss in northern Namibia. Firstly, it examines what types of information about the late parent is desired by children and adolescents, and how this relates to the knowledge provided by caregivers. Secondly, this section also gives an overview of diverse reasons, presented in a model, which contribute to limited intergenerational communication about the deceased parents.

4.2.1 Communication on loss

A discrepancy was found between the information that many children and adolescents would like to receive about their late parents and the information which their caregivers provided. The late parents were hardly discussed with the orphans, and generally little information was given.

Desired information

The majority of the adolescents and half of the group of orphaned children wished to receive information on three aspects: the parent's behaviour and character, their life circumstances and the cause of their parents' death. For instance, Martin, an orphaned child who lost his father at a young age who stayed with his remaining mother, wished to know about his behaviour: 'how he used to walk'. Some adolescents were interested in their father's character; these fathers had died when the adolescents were young, and had not lived together with their mothers. For instance, Petrina was interested in 'the type of person he was', and Meke wanted to know whether her late father had been supporting his children financially. Meke was also interested in getting to know her half-siblings, and her paternal grandfather, as she had never met them. Nelao, a double orphan, whose case is described below, indicated that receiving information about the late parents was important in order to understand her own behaviour. She noted 'sometimes a child can behave in a certain way and it is how the father or the mother was behaving'. Others were interested in their parent's life circumstances. For instance,

Martha, a single orphan who stayed with an aunt, was interested in how her father had lived. Her father had left her mother when she was pregnant with Martha, and they had not stayed in contact. She noted: 'I would like to know if my father was working, if he had many children, if he was married, if he had nice clothes, if he had poor health; maybe it contributed to his sudden death'. Receiving information about the parent, such as knowing one's half-siblings, and recognising one's own behaviour in that of the parents, seemed to be related to identity issues. These findings offer support for the argumentation of Neimeyer (1999) that loss may impact one's sense of self.

Several orphans, especially adolescents, wanted to know their parent's cause of death. For instance, Brigita said: 'It is just important for me to know the disease my mother was suffering from'. Some of them felt that the truth about their parent's cause of death was withheld from them. Wood et al. (2006) observed that wanting to know the truth about their parent's cause of death was utterly important for adolescents in Zimbabwe as well (Wood et al., 2006). The two cases of Nelao and Justin show that these adolescents were looking for the truth about their parent's cause of death, but that it was difficult for them to receive information. It shows their agency in their efforts to receive any insights. In their stories, their fear for HIV/AIDS as the cause of death of their parents shined through.

> Nelao's parents died when she was very young. Since then, she had moved between several households; she first stayed with her grandmother, after her grandmother died she stayed with her great-aunt, then with an aunt, with her elder sister and after she herself had a child, on her own. She was informed that her father had died in a car accident, but she also wanted to know what caused her mother's death. Her great-aunt had informed her about her mother's cause of death: 'She told me that she died because she had an abortion, but I do not know whether it is true'. To find out whether she was told the truth, Nelao intended to ask several family members about her mother's cause of death, such as her aunt, an uncle and her elder sister. She stated that she used 'magic questions' to get information: 'I am just asking questions slow – by –slow, here – by – here'. She had also asked a cousin of her mother who likewise had told that her mother had performed an abortion. She was however not convinced as her sister had said that their mother had been sick for two days and then died. She was also not sure whether her father died in a car accident, and had asked an uncle, who said that he had been abroad during the time of her father' death. Nelao was keen on knowing the cause of death of her parents because she wanted to know the truth. She

> explained: 'Sometimes people can tell you lies, which is not the cause of death of your parent. You don't know your parent's cause of death, and people would shout at you that your parents died of HIV, but that's a lie. So it is important to know so that you should not believe lies'.

The case of Justin resembles the argumentation of Nagler, Andropoz and Forsyth (1995) who worked with HIV affected families in the US; secrecy around HIV is more about *naming* then *knowing;* even if children are not told, they often suspect that something is wrong.

> Both of Justin' parents died when he was young. He remembered: 'My father came back sick from the town where he worked; he had swollen feet and ankles. When he came home he just died. My mum was staying in a nearby town; it is where she started to be sick. When she came to the village she also just died'. When Justin was young, he did not want to know about his parents' cause of death, as it would make him sad. Growing older, however, he wished to be informed. At the age of 19 he asked his father' sister about the disease his father had suffering from. She however could not give him any information. He suspected that his father's colleagues could provide him with information, but they stayed far away. He also didn't get any information about the death of his mother. An aunt and his grandmother, who had been taking care of his sick mother, only told him that the disease got so serious that she died. He stated: 'I have this feeling that they know but cannot tell me'. He might have suspected his parents had died of AIDS, as he stated that generally children should not be informed before the age of 18 about the cause of death of their parents, as it could be 'shocking', 'the child would think about how the mother suffered from the disease until death' and 'children might keep thinking that what caused their parents' death might as well cause their own death'.

Nevertheless, a significant number of the child participants did not desire information about their late parents. These children felt they had already been provided with enough information or that receiving information would make them sad; this is further discussed in the model below. A few adolescents similarly did not have a need for information about their late father as he had been absent in their lives before their death. For instance, Meke had not known her father, he died when she was small and her parents had not lived together. She noted: 'It does not help anything, even if I have information about him, I do not know him'. Also Foibe, whose father had already been absent in her life before he died, stated: 'Information about my father is of no use to me'.

Provided information

Orphans indicated that the deceased parents were not talked about much in their households, or not at all. For instance, the father of Liezel (a child orphan) remarried after Liezel's mother died. Liezel indicated that her father, stepmother and siblings almost never talked about her mother, as is also shown in the excerpt below, nor was Liezel informed about her mother's illness or cause of death:

VdB: Does your father or others talk about your mother at home?
L: No.
VdB: Would you like them to talk about her?
L: No.
VdB: Do you know what caused her death?
L: No.
VdB: Was she sick?
L: No idea.
VdB: Did she stay at home in the time before she died?
L: No.
VdB: Was she in the hospital?
L: Yes.

(Girl, individual interview)

This was not only the case for deceased parents: in some families, deceased individuals were generally never spoken about. The caregivers confirmed this picture. Many of them stated that they did not provide the orphans in their care with information about their late parents, or as minimal information as possible. Several caregivers felt it was unnecessary to do so. For instance, the maternal grandmother of Erastus, a paternal orphan, took care of him from a young age as his mother resided in another part of Namibia. She felt it was not needed to provide Erastus with information about his father - this could indicate what Baddely et al. (2010) called 'unspoken memory' (p. 198):

> I think for those who have pictures – pictures are just enough to show a child how the late parent looked like. I do not see it necessary to tell a child stories about the late parent.

The child orphans noted that when the late parents were discussed, caregivers talked about the late person's manners, whether the person had been supportive and caring, and 'things the person used to do' (Nile). A few adolescents expressed that the 'history' of their late parent was discussed. For instance, the work they used to do, the place where the parent had stayed, or the character of the parent. Caregivers similarly noted that they shared memories or talked about the

preferences of the deceased such as 'the jobs she used to do, the jokes she liked' (grandmother). These caregivers had known the deceased parent; for instance grandmothers who had lost a daughter or son a number of years ago. A few also showed pictures of the parent. 'Good behaviour' of the parent, and 'good things the parent used to do' were considered important themes to share with the child. This information was mostly used to encourage the child and to set an example, for instance, when caregivers corrected the child. A grandmother explained how she set her late daughter as an example:

> My daughter was a hard working person, she is the one who started up that garden of guavas, so sometimes now when people are working and her child is lazy we say to the child: 'Do not be lazy, your mother was a hard working person'.

Other caregivers felt that the deceased had to be remembered as they had 'left memories behind' (a grandmother), or mentioned that because of HIV and AIDS many children had lost the opportunity to get to know their parents and should therefore be informed:

> Children need to know who their biological mothers or fathers are, because nowadays, people are dying while our kids are still young; accidents are also increasing, the virus is also finishing us like nobody's business, so children must get a picture of their parents.

Some children talked with others in the household about their parents, such as with a sibling or a cousin, while others did not talk with anyone about their deceased parent. During the research period, Lena's sister died. The following abstract gives an impression of the way her late sister was talked about, which shows a general limited communication about deceased family members in Ovambo households:

> VdB: Do you and your family members sometimes talk about your sister?
> Lena: No, not really.
> VdB: Did you talk about her in the period after her death?
> Lena: Yes. We [the children in the house] talked about things we used to do together and about the jokes she liked to share. It was just some days; we did not really talk about her often.
> VdB: Do your parents talk about your sister?
> Lena: They somehow talk about her.
> VdB: When do they talk about her?
> Lena: When people are working. […] Especially when we are pounding, my mother would come and say that if she was around, then we would be pounding together. […] It was only said a few times. (Girl, individual interview)

4.2.2 Modelling obstacles in caregiver-child communication

The discrepancy between the desired and provided information, which is mentioned in the previous section, seems to be the result of various reasons that may limit communication between caregivers (including remaining parents) and the child or adolescent on parental death. In my study, various factors were found that hinder such communication; these factors are for a large part in line with reasons for limited intergenerational communication which are mentioned in the introduction. In this section, I present a model (see Figure 4-2) that shows how these factors, or obstacles, hinder communication from both the child and the caregiver's perspective.

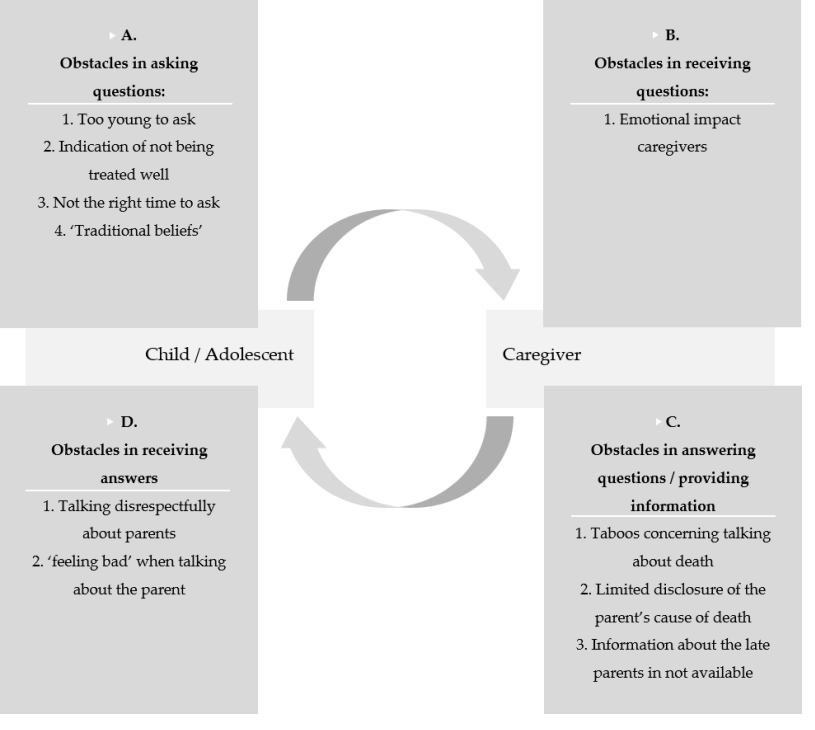

Figure 4-2: Obstacles in caregiver-child communication on parental death (Van der Brug)

This model is based on a communication model between sender and receiver, and gives an overview of how these different difficulties may relate to each other. The four categories of obstacles include: (a) obstacles perceived by children and adolescent in asking questions to the parents; (b) problems that caregivers experience in receiving questions; (c) reasons for caregivers to not provide

children and adolescents with information or answer their questions; and (d) difficulties which children may experience when they receive information about their parents. The various facets of these four obstacles are discussed below.

A. Obstacles in asking questions

A.1 'Too young to ask'

Generally, orphans did not ask questions about their late parents; largely because they were not allowed to do so. This was not unique for orphans; many non-orphaned children also indicated that asking questions about deceased relatives was not permitted. They would be told to keep quiet, that they were 'talking about useless things,' and that they should not talk about the person, as the person was 'long gone'. The majority of the caregivers confirmed that the orphans in their care had never asked for information about their late parents. This approach is in line with the emphasis on accepting death, which is mentioned in the previous chapter. This data also concurs with studies that report on the adult's power and authority in parent-child communication in diverse sub-Saharan African countries (Bastien et al., 2011) and reports indicating that asking questions by children would demonstrate a lack of respect (Denis, 2005). An important reason for not being allowed to ask questions included that children were considered too young to understand or deal with death-related issues. Various caregivers stated that children should not 'ask things which do not fit their ages'. Children confirmed this: they were considered too young to talk or ask about a deceased parent, and had to wait with raising such issues until they were older. Other caregivers felt that children already had sufficient knowledge about the parent. Furthermore, caregivers explained they were afraid that asking questions could lead to further questions, which they felt uncomfortable to answer.

If children asked questions, they were often ignored by caregivers, as the case of Martha and Hango shows. Martha, a single orphaned child who stayed with her aunt, mentioned that even though she asked a question about her father (with whom the family did not have any contact before his death), she did not receive an answer:

> Even if you ask, they do not answer you, unless you are sent something from school about your late father, they would answer you but if you are just asking and you are not sent, they are quiet.

The great-aunt of Hango, who took care of him from a young age while his mother resided somewhere else, noted:

> Children should not ask a lot about their late parents. If a child asks you once, the next time if he asks, you pretend to be busy for him to stop bothering you with questions.

Orphaned children felt they could start to ask questions about their late parents from ages 18 - 21 years onwards. Amongst the non-orphaned children 15 - 25 years were mentioned as the age that children may start asking questions about people who had died. Nevertheless, although the adolescent participants were of an age that a significant number of the caregivers considered them old enough to receive information, they were still not often informed, especially not about the cause of death. For example, Samuel, a double orphan, asked at the age of 20 several relatives about his mother's cause of death, but was told to wait. He was unhappy with the situation: 'I want to know now. It is my mother and not just somebody'. Other adolescents, like Meke, wished to get in contact with their deceased parent's relatives, but were not allowed to. Meke's father died when she was 6 years old. Her parents had not been married, her mother never talked about her father, and Meke had never met him. She was not allowed to visit relatives from her father's side, even though she had located some of her half-siblings. Notions of adult's authority and power in relation to children could play a role in perceiving children's questions about their parents as inappropriate or unnecessary.

In contrast, some caregivers, mostly remaining parents, differed from this opinion and stated that a child should be allowed to ask questions. Nevertheless, they still preferred the child to be older when given this information. A few orphans indicated they had been asking questions about their late parent. For instance, Festus, had asked if he had seen his father during his burial, as he had been too young to remember that. The mother of Martin explained that her son sometimes asked about his late father: 'when he sees a man passing by he would ask me if his father was of the same height and body as the man he sees'. Thus, he wished to get an image of what his father had looked like.

A.2 Indication of not being treated well

Children mentioned that they avoided asking about their parent because it could disturb their caregiver as it could indicate that they were not treated well. They remarked that even when a child is taken good care of by their caregiver, the child could think its life would be better when living with its own parents. Some children further indicated that they didn't ask questions because they were not 'feeling free' to ask. A lack of familiarity with their caregiver, or their position within the household withheld them from asking questions. The orphaned girl Martha, who stayed with her aunt, expressed that due to these reasons the people in her house would strongly disapprove of her asking for information about her late father. She indicated that she had to wait until she was older, before she could ask such questions:

> I always think of writing a letter to my [deceased] father, but if I write it and put it in my bag, people at my house like to search other people's bags. If they find it, the house would become small for me because they would be angry at me, not only would they be angry, I would also be beaten, not only that, they would also be complaining endlessly, and I would not be allowed to eat.

This was confirmed by caregivers: some caregivers considered talking about the late parents to be inappropriate for children, as it could show that a child was not treated well in the foster household. The great-aunt of Festus explained this by noting: 'Only if the child is not happy in the household, that is when he would bring up something like that, otherwise he will not'. As has been noted in the previous chapter, foster caregivers were supposed to treat orphans well in order to enhance the process of forgetting. Thus, by asking questions, the child was considered to be still thinking about his or her own parents and not content with the treatment of its foster caregivers.

A.3 'Not the right time to ask'

Some adolescents indicated they had not asked questions about their deceased father as they had not found the right time to ask these questions. For instance, Claudia and Foibe, both parental orphans, stayed with other relatives instead of with their remaining mother from a young age. Claudia joined several households of relatives, including those of her aunts and grandmother, and stayed only with her mother during holidays. Foibe, who grew up at her aunt's house only saw her

mother on the rare times she came to visit her. These contexts of fosterage made it difficult for them to ask their mothers about their deceased fathers. Both suspected their mother could answer their questions; however, not living with their mothers inhibited them from asking. They noted: 'I did not get the right moment to ask her' (Foibe), and 'If I stayed long with her I could ask her, but not in this situation' (Claudia). Thus, due to their fosterage situations, these girls felt that their somewhat distant relationship to their mothers prevented them from asking information about their fathers.

A.4 'Traditional beliefs'

The adolescent orphan Brigita was not allowed by the great-aunt she grew up with – a traditional healer – to ask for information about her father, or look for him. This was the result of what she called 'traditional beliefs'. During the 2003 study, both her great-aunt and she stated that she was a paternal orphan. As an adolescent, her mother died as well, due to AIDS. In the period after her mother's death, she came to know that her father was not dead after all. Her great-aunt had told the household members that her father was alive, but did not inform the girl herself. She got to know this information through other children who lived in the household. The girl had first opposed to not being allowed to search for her father, but had later accepted it. She could not reveal these beliefs, as they were secret, and her grandmother had forbidden her to talk about it. Further research is needed to gain insights into these beliefs.

B. Obstacles in receiving questions

B.1 Emotional impact caregivers

Some of the caregivers, especially remaining parents and grandparents, noted that questions from children about their parents had a strong emotional impact on them. Studies from South Africa also show that bereaved children's caregivers may face high levels of grief and depression (Boon et al, 2010; Kuo & Operario, 2011). For instance, the mothers of Helena and Martin mentioned that their children should not talk or ask about the late parent, as the questions confronted them with the loss of their partner. Helena's mother also explained it reminded her that her children had to grow up without a father, and that such questioning would hurt her. Thus, she would prevent Helena from asking such inquiries,

stating: 'So you have to find a polite way of stopping her from talking about the father'. In both cases the father –most likely – had died of AIDS. Martin's mother did not reveal that her husband died of AIDS, however, during the research she herself died as a result of being HIV positive. Her remarks about the reasons why she did not want her children to ask her questions, as the excerpt below shows, could indicate that she might feel sad or bitter towards her husband as he was HIV infected:

> Sometimes if a child starts to ask you, they are heart moving questions, because I would not be in a situation where I am now. It is always on my mind that he left alone me with many children. (Mother of Martin)

Orphans similarly expressed that the emotional impact of their questions withheld them from asking questions. They mentioned that such questions might upset their caregivers: 'It makes people feel sad' and 'They might cry'. For instance, Alex, an orphaned adolescent explained that he had many questions about his late father but that he could not ask them: 'My mother does not like that part. She says it brings her bad memories'. DeMaso et al. (1997) similarly found that parents, who lost a child, experienced talking about their deceased child with their surviving children as an emotional burden (p. 1299). However, how remaining parents and other caregivers respond to the death of the child's parent may have an impact on the way children deal with the loss. For instance, a study on childhood grief in the United States showed a strong association between childhood traumatic grief and caregivers' emotional reaction at the time of the death and their current sadness (Brown et al., 2008). Thurman, Taylor, Luckett, Spyrelis & Nice (2018) similarly found in their study among bereaved adolescent girls in South Africa that grief among caregivers was associated with adolescent's grief. In the same line, Young and Papadatou (1997) argue that because children are dependent and reliant on others to care for them and assist them to adjust to a life without the parent, the emotional ability of children to cope with parental loss depends to a large extent on how the family manages the loss (p. 198, 201).

C. Obstacles in providing information and answering questions

C.1 Taboos concerning talking about death

As has been noted earlier in this chapter, taboos regarding talking to children about death could be a hurdle for the parents (Daniel et al., 2007 (Uganda); Van

der Heijden et al., 2010 (South Africa)). Although remembering a late person was generally considered appropriate amongst the Ovambo, as is discussed in the previous chapter, talking about death was, however, inappropriate. Talking about death is often considered a taboo as it is seen to be foretelling, and 'may lead to death in the family'. A grandmother explained that mourning practices were perceived to be especially predictive: 'If someone starts to sing mourning songs but no-one has passed away, it is obvious that it is foretelling that something will happen'. During the research, I came across various restrictions which are based on connections with death. For instance, it was incorrect to bring sleeping necessities when staying over in an Ovambo homestead, as the bringing of bedding was normally done by relatives who came to mourn, and this could thus foretell a death. An NGO worker explained that in the past, death was regarded as a taboo and that even nowadays, many things connected to death were feared. This fear is also described by the missionary Tönjes (1996 [1911]), who wrote about the Ovambo: 'The thought of the ultimate destination [death], towards which they are all headed, frightens the people, and they prefer not to think or speak about it' (p. 141). Due to this fear, the majority of HIV infected mothers did not make arrangements for their children in case they would die, as the NGO worker explained:

> A mother cannot tell her children about the time that she will not be there anymore. It is like a taboo, you do not talk about things before they happen. If you talk about it, you want it to happen to you, which mean you want misfortune to come your way. It is like cursing yourself. So the issue is very sensitive.

C.2 Limited disclosure of the parents' cause of death

Caregivers' often provided no or limited information about the late parent's cause of death. The Ovambo society has a tradition of not disclosing a deceased's cause of death to children. In the past, children were almost never told about the sickness which led to the death of a parent and even now caregivers indicated that it was 'difficult' or 'unnecessary' to inform children about it. Caregivers would only provide the information that the person had been ill and died, and noted they would wait until the child was in his twenties and would ask for more information. For instance, the great-aunt of Brigita expressed: 'We are not talking about the cause of death or the sickness, only what the person used to do'.

Furthermore, some caregivers who were not closely related to the child in their care indicated that disclosure of the late parent's cause of death was the responsibility of closer related relatives.

Caregivers hereby differentiated between hidden and non-hidden causes of death. Illnesses that were hidden, such as HIV/AIDS, were usually not shared with children. However, accidents and diseases which were known to other people before the ill person died were considered easier and more appropriate to discuss with children. Likewise, in South Africa, AIDS as the cause of death is little talked about as it is considered an inappropriate death (Benedict, 2003). It is also seen as a 'bad death': the death of young and middle aged people, instead of the expected and unthreatening death of elderly people (Posel, Kahn & Walker, 2007, p. 139). Furthermore, Demmer (2007) describes that in South Africa, AIDS as the cause of death was minimally shared amongst people due to its association with witchcraft. Ashforth (2002) similarly found that many of his respondents in South Africa indicated that they knew people who believed that AIDS was due to witchcraft and this inhibited them from sharing the cause of death with others. In contrast, teenage orphans in Zimbabwe indicated that adults preferred to mention the role of witchcraft in many deaths, as the truth – AIDS as the cause of death – was too painful (Wood et al., 2006). In my study, caregivers did not often refer to AIDS by name, but used euphemisms, such as 'this new disease we have in our nation' which indicates the silence and secrecy HIV and AIDS are surrounded with.

Limited HIV disclosure

Less than half of the orphaned participants said they were informed about the cause of death of one or both their parents. Several of those who said they did not know the cause of death were told their parent had died of an illness. Two participants mentioned AIDS as the cause of death. Others mentioned their parents died of car accidents, cancer, malaria, suicide, stress and murder. Many caregivers did not confirm this information. For instance, Hango had explained that his father was killed by robbers; however, his grandmother stated that this was not the truth, and that she would only inform him about the cause of his father's death once he was older. However, more parents died of AIDS than mentioned above. For instance, the caregivers of three orphans, stated they had disclosed to these children that their parents had died of AIDS. However, the

orphans themselves had expressed during the interviews that they did not know their parent's cause of death. Possibly, they wished not to share this information, and keep their parent's HIV infection secret. Thupayagale-Tshweneagae & Benedict (2011) found that orphaned adolescents in South Africa, who maintained the secrecy of their parent's death, did not talk with many of their friends or even with their caregivers about their parent's cause of death (p. 358). They argue that such secrecy made their grieving more difficult (*ibid*.).

Other orphans appeared to be not informed about AIDS as the parental cause of death. The great-aunt of Brigita, who cared for her from a young age, expressed during an interview that her mother had died of AIDS – even though she received ART – but that they had not informed her. The girl was only told her mother was ill; the great-aunt stated: 'We only told her from the beginning that her mother was sick, we did not tell her what kind of disease'. Martin's mother died because she was HIV positive; the boy was only informed about her illness after her death – as is described in Chapter 2. Although his mother had stated in interviews she was in favour of disclosing the parental cause of death to children when they started school, it is likely that she had not informed him about his father's cause of death, who died years earlier. According to the boy he was told that his father had 'collapsed and died'.

Furthermore, several caregivers hinted during interviews that the deceased parent(s) had been HIV positive, which might indicate that the actual rate of AIDS deaths was higher than the cases mentioned above. Concerns mentioned by caregivers such as that children 'might think a lot about it' or that a child 'could think that he might carry the disease of his mother' seemed to refer to HIV, although this was not verified. For instance, Hilma's great-aunt stated that her father died because he was sick 'lying thin for a long time in the hospital bed until the time he passed away'. Yet, she did not inform the children in her care, including Hilma, about the cause of their father's death due to the following reasons:

> I did not tell them, because of circumstances surrounding the death of a father. They are only told that their father passed away but were not told the specific illness the father was suffering from. When they have grown up, they should be told that your father died this kind of death, so if you are not behaving you will die. If I tell them when they are young they might be scared or shocked because some circumstances surrounding the

> cause of death are shocking and the child may think that; I might be carrying the disease my father had.

Suicide as the parental cause of death was likewise not always told to children, but appeared less stigmatised than HIV as both the caregivers and the orphans spoke openly in interviews about suicide being the cause of death The fathers of two participants committed suicide. Both girls were informed about their father's suicide at the age of 9 or 10 years. Although one of them was told immediately after her father's death, the other was only told years after his death. Her caregivers had waited with telling her when she was 'a bit grown up', but had not shown her the place where the suicide had taken place as it might bring her 'bad memories.'

Thus, this section shows that a significant number of the orphans were most likely not informed about HIV as the cause of their parent's death. This assumption is in line with the high numbers of AIDS deaths in northern Namibia in the years that the participants' parents died (see Chapter 1). A low rate of informing orphans about AIDS as the parental cause of death is in accordance with a low HIV disclosure rate of parents to their children worldwide as well (Qiao et al., 2011). This might indicate that caregivers are concerned about the negative consequences of HIV disclosure of their late parents to children. Reasons for both disclosure and non-disclosure are discussed in the following section.

Reasons for HIV disclosure and non-disclosure

An important reason for caregivers *to inform* children at a young age about the late parents' HIV infection included the mother-child transmission of HIV. 'The child has to be taken for a test' and 'the child has to go on treatment' were mentioned as reasons to inform the child. Nevertheless, children were not always told about their own HIV infection: the lack of disclosure of children's HIV infection by parents has been documented (Abebe & Teferra, 2012). In this study, at least one child participant was not informed about her HIV positive status. A doctor working in a nearby hospital stated that a large majority of juvenile HIV infected patients did not know their status. A second reason in favour of disclosure included that children might otherwise hear it from others, such as fellow learners at school. Thirdly, orphans were informed about their parent's HIV infection as it could help to protect them against contracting HIV. For instance, caregivers mentioned 'so the child can take care of itself', 'the child can be beware of things'

and 'the child knows it should behave well'. Fourthly, caregivers expressed their concerns that children would lose their trust in them when they were not told the truth about their parent's cause of death. Caregivers indicated that it could for instance occur that children were looking in the late parents' health passport and found out about their HIV infection. Except for mother-child transmission, the reasons mentioned in this study resemble the main reasons for parental HIV disclosure mentioned in the global literature (Qiao et al., 2011; Schrimshaw et al., 2002).

HIV-related stigma and shame were mentioned as an important reason for *non-disclosure* of the late parent's HIV infection – or delayed disclosure, when children had reached adulthood. For instance, caregivers were concerned that children would not be able to keep the diagnosis secret, and that the parent was talked about negatively. This fear was also found by Palin et al. (2008). A caregiver gave an example: 'They would say: her mother was behaving badly'. Also the aunt of Taiwo, who took care of him and who was HIV positive herself, felt that stigma in relation to HIV/AIDS was still present in Namibia. She noted that Taiwo was told at a young age that his parents had died of AIDS. He was informed because his older sister was also HIV positive, and Taiwo had to go for testing as well. His aunt however would have preferred to tell him later, due to the related stigma:

> Diseases like HIV need to be kept secret because of the stigma attached. It can only be told to a child who can be trusted and would not say it to anyone here and there. Stigma is not really a lot because people are now told how it is spread and how not, and because many people are on ART. But there are still those who see people with HIV in a different way.

Furthermore, caregivers indicated that children would be teased or bullied when it became known that their late parent was infected with HIV. Schrimshaw et al. (2002) found the same concern in their US study, where parents did not want their children to experience rejection by other children. Thus, the fear for 'associated stigma' (see Philips et al., 2012; Holzemer et al., 2007). In my study, HIV infection was a reason for bullying. For instance, a double orphaned boy who stayed with distant relatives was HIV positive himself – his case is described in Chapter 2. The boy was bullied by children from nearby houses, as one of his caregivers had disclosed to neighbouring houses that he was HIV positive. The caregivers noted that the boy did not want to bring *Oshikundu*, a millet drink, to school anymore as he was bullied by other children:

> Children would ask to drink from his oshikundu. But they only poured it out saying that they cannot drink from a container of a HIV positive person. After that he did not want to go with oshikundu to school again.

Due to such experiences or observations, several adolescents felt that the parental cause of death should not be told to children before the age of 18 or 19. For instance, the single orphan Alex indicated that HIV should be kept a secret for children, as children would not take it 'as a serious case':

> HIV is embarrassing; children should not be told about that. Sometimes children would be asked: 'What caused the death of your parents?' The child says: 'HIV/AIDS'. Others are listening and from there, they would be shouting at each other: 'Your mother died of HIV/AIDS'. At the primary school, some students who do not know how to behave, they would just say in public, 'Your mother died of HIV/AIDS'. Because that is what they heard from their mothers.

Also Grace, whose grandmother disclosed to her as a child that her parents died of AIDS, indicated that HIV/AIDS was too 'confidential' to tell children. She stated that children do not 'keep things to themselves' and would tell others at school. As a child, she had disclosed her parent's illness during a session of the 'Windows of Hope' programme at her school, when asked whose parents had died of AIDS. However, she regretted this later: 'I was ashamed, when I later realised how people contract the disease, where it comes from and what the disease is all about'. This example also shows that experiences of loss and grief take place within a social context, with higher-level processes influencing the local social context. Grace learned in a setting of a government and UNICEF-led HIV prevention campaign and through learning the meanings of AIDS that her parents have not 'just' died, but died from a 'shameful disease'.

Caregivers were also concerned that knowing about the HIV infection would have negative consequences for the emotional wellbeing of the child, and intended to protect the child by not revealing this information. Concern about the emotional burden of parental HIV disclosure for the children was also expressed in the global literature (Schrimshaw et al., 2002; Palin et al., 2008; Thomas et al., 2009). In my study, such information was considered 'very shocking', 'scary' and 'disturbing' as the child would think about how the parent had died and how the parent had suffered in the period before their death. The child might ruminate on how they were informed of the HIV infection of the parent, and the child could think that he or she 'might be carrying the disease my father had'. These issues are

similarly mentioned by Wood et al. (2006) and Demmer (2009) as aspects of AIDS-related bereavement. Concerns further included that the child would be worried and pre-occupied, and it would affect the child's concentration at school, as the child 'might be thinking a lot'. Adolescents similarly mentioned such negative consequences as a reason for not being told about their parental cause of death. For instance, Brigita expressed that she was not informed by her caregiver because 'maybe she does not want me to think a lot about it. It might be bad'.

Adult factors were mentioned as well. Caregivers and parents felt that disclosing AIDS as the cause of death was difficult as it was 'hard to tell the child' or a HIV positive child could blame the HIV positive remaining parent for having infected them. Caregivers expected many questions from the child, and did not know how the child would react. Thus, taboos around death and HIV, and fear for the emotional consequences often prevented parents and caregivers sharing information with children.

C.3 Information about the late parents is not available

Another reason for limited communication is that caregivers often could not provide the child with information or answer questions about the life circumstances of the parent, as they simply lacked such information. This was especially the case when a child stayed with distant relatives, or when the late father had not been present in the child's life before his death. For instance, Hango' caregiver, his great-aunt, expressed: 'I do not know anything about his father so I really cannot tell him about his father'.

D. Obstacles in, and impact of, receiving information and answers

D.1 Talking disrespectfully about parents

Information that children received about their parents did not always correspond with the information children wanted to hear, for instance when the parent was spoken about disrespectfully. Several adolescents mentioned their parents were talked about without respect in the household where the child stayed which made them 'feel bad'. Brigita, who stayed with her great aunt, related that her mother was sometimes talked about negatively in her home. Her mother had been HIV positive; however her great aunt had not shared this information with her.

Possibly, these negative remarks were related to the mother's HIV infection. The excerpt below shows Brigita' feelings about such opinions:

> If your mother did not behave well, and she used to do bad things, and the story would be told in front of everyone, where other children would go and make fun of me about what my mother used to do, then it is not good that they talk about my mother. And these children would say their mothers do not do things like that.

The grandmother of the double orphaned adolescent Grace moved in with her and her siblings, after her parents had died. Her grandmother often talked negatively about Grace's father, as her father had infected her mother (the daughter of Grace's grandmother) with HIV. For Grace, who had been fond of her father, such negative remarks were painful. She explained:

> I just decided not to talk about my parents anymore because grandmother would talk about them in a negative way. If it is about my mother, it is fine. But if it is about my father she would say that my father does not know me. When she speaks about my father she says that he was killing people, that he had bad manners, that he is dead and that he never went to church.

Some caregivers also referred to the negative behaviour of the deceased parent in order to correct a child. For instance, they would tell the child it was lazy just as his/her mother had been lazy. Yet, other caregivers stated that such negative behaviour should not be mentioned as 'the late has gone with her bad things' and such information would negatively impact children.

D.2 'Feeling bad' when talking about the parent

Although many children wished for information, at the same time, talking about their deceased parent made them unhappy. Most children stated they were 'feeling bad' when their parents were mentioned or talked about in the household, because of their fear of discussing death and because they were reminded about their loss. This was expressed by many children, they noted for example: 'I do not like a dead person to be spoken about' (Festus), 'It makes me think about them' (Kagumbo), 'It makes me cry' (Erastus), 'It makes me unhappy' (Justin), 'Because I do not have him' (Martha) and 'I would dream about my mother' (Liezel). It has already been mentioned in the previous chapter that 'thinking about' their parent was perceived in an adverse manner by the children and was associated with the absence of the parent in their lives.

Generally, talking about a deceased person was perceived negatively by the children. Most of the non-orphaned children similarly disliked it, due to the fear of death or because it would make them think about the person. They stated: 'You are also afraid to die' (Silas), 'You are afraid your mother will die' (Veijo), 'You would dream about the person lying next to you' (Charles), 'You will keep on thinking about the person' (Helvi). Only a few expressed that one should talk about a deceased relative in order 'to learn about what the person used to do' (Nile).

Several adolescents additionally felt that receiving information increased their 'thinking about their parents' and thus their sadness. Some of them felt that children should therefore not receive information about their parent. Some orphans even regretted that they had received information about their parent as it had increased their sorrow. For instance, Hilma had always wished for information about her father. However, after she was told about her late father's personality and living circumstances, such as 'who he was, how he was like, and where he was working' and had received a picture – she realised that it had made her unhappy. She noted:

> It is not good to know things because you will be thinking about your father, and you will be crying most of the time which is not good. Even if I am busy with something and start to think about my father I start to cry; because I do not know him, but others know their father.

Thus, children's and adolescences' preferences to communicate or keep silent about parental loss are not always fixed notions, but can change over time. Whereas Hilma wanted information when she was younger, this desire was no longer present once she reached late adolescence. In contrast, others (like Justin) did not want to receive information about their late parent when young, but did so a few years later. Such changed wishes were caused by childhood fears regarding talking about death which diminished with age, and by the realisation of adolescents that increased knowledge about the parents would likewise increase the absence of the parent.

4.3 DISCUSSION

This chapter noted that limited caregiver-child communication about parental loss was found – this data concurs with previous studies that explored such communication conducted in sub-Saharan Africa (Wood et al., 2006; Daniel et al., 2007; Van der Heijden et al., 2010) - and focused on reasons causing this silence.

Amongst children and adolescents, both a preference for talking and silence about the late parent was found. The ones who wished to obtain information wanted to know the truth about their parent's cause of death and wished to form an accurate picture of their parent and their parent's life. Gathering information also seemed to be related to identity issues. Certain psychosocial intervention programs for parentally bereaved children, such as creating memory boxes and memory books, are based on the premise that the sharing and preservation of memories is vital in the identity processes of orphans (Witter et al., 2004, p. 139). The basic assumption of these programs is that children, who have a positive recollection of their parent's illness or death and know the history of their parents, are better able to develop resilience and cope with the hardships of their condition (Denis, 2005). However, a major discrepancy was observed between the information that children and adolescents wished for and the information they received from their caregivers.

The children and adolescents opting for silence preferred not to talk about their late parent as they said that silence protected them from feeling sad and 'thinking a lot'. Silence as a way of dealing with the emotional impact of questions about loss was also found amongst remaining parents and some of the grandparents. Thus, in these households the emotional impact of questions about the late parent was an important motivation for inhibited communication. Protection from sadness as a reason for silence in dealing with death is also found in other studies (Silverman et al., 1995; DeMaso et al., 1997). This approach could be interpreted as grief avoidance, which falls under the restoration orientated approach in the Dual Process model of coping with loss (Stroebe et al., 1998). Stroebe et al. (1998) describe how grief avoidance might also be a respite from coping at all. Silence in dealing with loss also corresponds to the emphasis on acceptance and forgetting in northern Namibia, which is discussed in the previous chapter. However, such silence among caregivers could influence the grief responses of children. Research suggests a relationship between the grief

responses of caregivers and children (Brown et al., 2008; Thurman et al., 2018). In contrast to silence, caregiver-child communication is seen to have a protective role in contexts of adversity in a southern African setting (Govender et al. 2014).

This chapter presents a model (Figure 4-2) which gives insight into how multiple factors obstruct communication on parental loss in various phases of the communication trajectory between caregivers and children. These factors were subdivided into: obstacles in asking and receiving questions by the child or adolescent, and obstacles in receiving answers, answering questions or providing information by the caregiver. One of these factors included the generational and social positions of children. For instance, notions of adult's authority and power in relation to children seemed to play a role in considering children's questions inappropriate or unnecessary. Lambek and Antze (1996) reflected on the influence of the social context on memory production and reproduction, and distinguished power as an essential factor which influenced this process. A few adults in my study perceived the position of children and adolescents differently; they believed that children had the right to ask questions, and receive information about their parents. This viewpoint was largely the result of the HIV epidemic causing many children to grow up without having known their parent.

Caregivers' decisions to withhold the parental cause of death from children seemed to be, for a large part, HIV related as well. The findings show that a significant proportion of the orphans were not informed about AIDS as their parent's cause of death. HIV-related stigma was one of the reasons for not informing children, as it was feared that children could not keep secrets. Research suggests that stigma related to HIV/AIDS is stressful for elderly caregivers in Southern Africa who had lost a child or grandchild due to AIDS (Boon et al., 2010). This study found that the extent to which such stigma was experienced and perceived by caregivers was strongly associated with their grief (p. 62). When children were informed about the HIV infection of the late parent, caregivers took the risk of associated stigma into account to varying degrees. Some children were warned not to tell others, but others not; as a result, as adolescents they regretted having talked about their parent's HIV infection. Orphans also spoke of associated stigma and shame, for example a HIV-positive orphaned child experienced such stigma. The stigma process which is described by Holzemer et al. (2007), is helpful in understanding this phenomenon. For instance, this model gives insight into the stigmatisation of this HIV-positive child: disclosure of his HIV-positive status by

his caregivers to neighbouring houses (stigma trigger) led to insults by children from his neighbourhood (stigma behaviours), thus causing received stigma (type of stigma), which ultimately led to a decreased quality of life as he was bullied (stigma outcomes). Thus, even though the Namibian health care system offers good access to ART, HIV-related stigma still existed in the research setting – which acts as a barrier for successful prevention (Turan et al., 2012). Studies on stigma within other African countries show similar findings (Peltzer et al., 2011; Turan et al., 2012; Chan et al., 2016).

Madhavan (2004) argues that attention for fosterage patterns is essential in understanding orphans' circumstances, particularly in the context of the HIV epidemic (p. 1443). This study provided several examples of the importance of taking fosterage patterns into account. For instance, children staying in foster households would not ask for information about their late parents as this could indicate that they were not treated well in the household. Alongside this, in households where children were taken care of by distant family members, information was not available as the caregivers had not known the parent, for example. Furthermore, adolescents who stayed in foster households and only met their remaining parent sporadically believed that a short meeting with the parent was not the right time to ask for such information. Besides this, it was painful for orphans, when in their foster homes, if their deceased parents were talked about in a disrespectful way. Thus, contexts of fosterage influenced and obstructed caregiver-child communication in various ways.

5

Childhood grief and economic insecurity

5.1 INTRODUCTION

To understand childhood grief in Namibia, seen as the subjective experience of loss (Melhem, Porta, Shamseddeen, Walker Payne & Brent, 2011), the financial aspects of parental loss should be taken into account. In the bereavement literature, the impact of the financial consequences of the death of a parent, partner or child on grief experiences is understudied. Corden and Hirst (2008) note that the impact of bereavement is mostly considered 'in terms of health and psychological wellbeing and the role of services to support people through their grief and loss', whereas economic consequences of bereavement have received less attention (p. 209). However, the economic outcomes after the death of a partner or a parent may be *part* of the grieving experiences. For example, a study on South African Zulu widows living in extreme poverty (Rosenblatt & Nkosi, 2007) shows that a part of the widower experience was expressing their grief in terms of the financial effects of their partner's death. The widows described how they would especially think about their husband at the end of the month when he would receive his salary, or that they missed him because their husband would always try to support the family financially (p. 75). A quantitative study among bereaved adolescent girls in South Africa found that economic stressors due to this loss were associated with increased odds of complicated grief (Thurman, Taylor, Luckett, Spyrelis and Nice, 2018).

In Namibia, the loss of parents may have serious financial effects on the lives of children. Child poverty rates are high in households with orphans (39.3%) (Namibia Statistics Agency [NSA], 2012). This chapter discusses children's grief and their responses to bereavement after the death of their parent in northern Namibia in relation to *financial insecurity* as a result of parental loss. The next chapter will focus on childhood grief in relation to social insecurity of orphans in their households. The first question explored in this chapter is: (i) How do the financial consequences of parental loss, as perceived by children, affect their experiences of loss and grief? Since 2002, Namibia has scaled up state-provided social welfare grants for orphans in order to tackle child poverty (National Planning Commission [NPC], 2010). The second question relates to: (ii) How does

the support of orphans (for example: by the state) influence the economic security of the orphaned participants? In the following sections, literature relating to the following themes is examined: the concept of human security; the impact of the loss of socio-economic security on processes of grief in general; and the socio-economic consequences of parental loss on orphans. Many children in Namibia, both orphans and non-orphans, experience the consequences of poverty and unstable households. For instance, Namibia has a general child poverty rate of 34% (NSA, 2012). Therefore, the effects of orphaning are discussed in relation to socio-economic uncertainties of non-orphaned children growing up in similar contexts of poverty and HIV/AIDS. Afterwards, the empirical data on the economic insecurities of orphaned children in Namibia, their grief, and the forms of support for orphaned children are discussed.

5.1.1 Human Security

The concept of Human Security can be a valuable analytical tool in comprehending how economic and social consequences of parental loss affect children's experiences of loss and grief. This concept, 'asking for the ways in which people in different circumstances strive for security, and conversely identifying the factors that render them insecure' (Eriksen, 2005, p. 2), integrates a variety of aspects which are important for human well-being. Eriksen argues that although the concept of Human Security has been criticised for being vague, difficult to operationalise, and not contributing to existing terminology, this concept is valuable for 'reorienting social theory and building bridges between the different social sciences' (*ibid.*). In the Human Development Report "New Dimensions of Human Security" (United Nations Development Programme, 1994) the following aspects of Human Security were distinguished: economic, food, health, environmental, personal, community, and political securities.

In the early 1990s, the Human Security paradigm was adopted by the United Nations Development Program. It was further embellished in the United Nations Millennium Development Goals passed in 2000. Former Secretary General of the United Nations Kofi Annan described Human Security as, Annan (2001):
'During the Cold War, security tended to be defined almost entirely in terms of military might and the balance of terror. Today, we know that 'security' means far

more than the absence of conflict. We also have a greater appreciation for non-military sources of conflict. We know that lasting peace requires a broader vision encompassing areas such as education and health, democracy and human rights, protection against environmental degradation, and the proliferation of deadly weapons. We know that we cannot be secure amidst starvation, that we cannot build peace without alleviating poverty, and that we cannot build freedom on foundations of injustice. These pillars of what we now understand as the people-centred concept of 'Human Security' are interrelated and mutually reinforcing.' (p. xix).

My study on childhood grief of orphans in northern Namibia started under the research programme Constructing Human Security in a Globalizing World (CONSEC)[10] at the department of Social and Cultural Anthropology at the Vrije Universiteit Amsterdam. Within the programme, research focused on the dynamic relation between security and insecurity in human lives in the contemporary world, on the level of individuals, local communities, states and global policy networks. People's perceptions and experiences of security and insecurity have been studied as well as processes like identity formation and in- and exclusion. As described in the research program, a one-dimensional, top-down image of human security does not offer a complete picture of this concept (Faculty of Social Sciences, summarised program description, 2007). Attention to the cultural and existential dimension of human security, like how individuals make sense of the world, find a place in it, and create some measures of certainty and predictability, contributes to the understanding of human security.

In chapter 5 and 6, the focus will be on understanding how children orphaned in the context of the HIV epidemic experience security and insecurity. In this chapter, economic security will be addressed, whereas the next chapter focuses on the personal security of children, which has to do with protection from both physical and verbal violence, and unjust treatment. The aspects of income, personal security and a safe place to live will be integrated in the following sections by addressing 'socio-economic security'.

[10] This programme evolved in the new research programme MOBB: Mobilities, Belonging and Beliefs: Confronting Global Inequalities and Insecurities.

5.1.2 The impact of the loss of socio-economic security on grief

The impact of the loss of socio-economic security on grief has been studied in diverse contexts. In their study amongst older adults in the United States, Norris and Murrell (1990) identified factors that contributed to post-bereavement depression and physical health 9 months after the death of a spouse. The study found that, amongst widows, higher financial pressures after the death of a spouse was an independent risk factor that contributed to bereavement-related depression (*ibid*.). A study conducted in the United Kingdom showed that caring for a disabled or chronically ill child often financially impacts families, with potentially long-lasting negative effects on income and employment (Corden, Sloper & Sainsbury, 2002). This impact affected the responses to bereavement of some parents who participated in the study: ongoing financial difficulties after the death of their child affected their healing process after bereavement (p. 203). Thus, as Corden et al. (2008) note, the way people respond to bereavement may be influenced by the financial and economic consequences following the death of a loved one (p. 209).

Already living in resource poor areas may even strengthen this relation between economic loss and grief after the death of a partner, parent or child, as evidenced in the case of South African Zulu widows (Rosenblatt et al., 2007). Another study conducted in South Africa, found that post-loss economic hardships contributed to complicated grief among adolescent girls (Thurman et al, 2018), as has been mentioned in the introduction. In this study, complicated grief was defined as grief that does not resolve within six months, and was measured by using the Inventory of Complicated Grief-Revised for Children (ICG-RC) (Prigerson et al, 1995) in conjunction with grief-induced functional impairment. Almost half of the participants experienced post-loss economic hardships, and these adolescents had 88% greater odds of complicated grief compared to their peers who experienced economic stability (Thurman et al, 2018, p. 84).

In countries where safety nets to soothe the economic effects of a death in the family do not exist, such deaths may have strong repercussions on the financial security of households. Nordanger (2007) found that in Tigray, Ethiopia, one of the poorest areas in the world, a death within a poor household is seen to cause deeper and longer-lasting sorrow amongst the family members than when a richer household suffers a similar loss, as the increased poverty in these

households continually reminds the bereaved of their loss (p. 180). Every death of a person who contributes to the household income disrupts the ecology of a household (p. 179). Nordanger observed that participants would often refer to 'the loss of a household member in terms of household erosion or in terms of the deceased person's former inputs to the household', next to considering the 'broken love' as the main emotional consequence of the loss (*ibid.*). Nordanger noted that bereaved people often expressed their loss in phrases such as: 'The sorrow for my husband is deep, because who is going to plough the land now?' or 'I am grieving for the loss of my son, because he was the one who saved us from the last drought' (*ibid.*). Against a background of marginal socio-economic conditions in the Tigrayan society, 'it might be both natural and functional that expressions of distress concentrate on basic and urgent needs for survival, and that coping norms concentrate on ''forgetting'' rather than indulging in sorrow', Nordanger states (p. 188).

The expression of loss and distress in socio-economic terms is similarly found in studies that have looked at the relevance of using a trauma framework to understand peoples' experiences of war in different cultural contexts. Within this debate, scholars have criticised the export of the American-originated psychiatric concept Post-Traumatic Stress Disorder (PTSD) to other post-war settings, as it does not necessarily translate into other social, cultural and political contexts (Bracken, 1998; Summerfield, 1999). Furthermore, Eyber and Ager (2004) note that the export of this biomedical concept is scrutinised for neglecting local understanding of distress, and people's own perceptions and meanings that they attach to events (p. 190). For instance, they found in their study on young people from war-displaced communities in Angola that the majority of youths showed signs of PTSD. However, one of the issues that the youth found most distressing was the lack of clothing and shoes, as having appropriate clothing prevented them from being branded as outsiders and helped them to integrate into friendship groups (p. 201). Kagee (2004) found that although South African survivors of human rights violations during the apartheid era showed signs of PTSD, economic marginalisation was amongst their most pressing concerns, rather than symptoms of traumatisation (p. 625). Boyden (2004) observed in focus group discussions with young people in northern Uganda, who had been abducted and held captive in armed conflict, that even if they displayed symptoms commonly associated with PTSD their overriding concern were socio-economic needs instead of the

horrifying past events (p. 252). Biomedical models to understand incidents of distress, including grief after the loss of a loved one, might thus not necessary fully capture such experiences; the socio-economic consequences of loss and other stressors are important as well. The following section therefore focuses on these consequences of losing parents in a context of poverty and HIV/AIDS among children and adolescents. The section also addresses the question in how far these insecurities are specific for orphans, or whether these insecurities occur among non-orphaned children as well.

5.1.3 Socio-economic insecurities of orphans in contexts of poverty and HIV

Orphaned children and adolescents from resource-poor communities often have to cope with the socio-economic burdens of parental loss. Van der Heijden and Swartz (2010) argue that in parts of South Africa, both poverty and the extent of the HIV epidemic impacts children's social and environmental contexts. When children in these circumstances become orphaned, worries about the economic and social effects of parental death are often part of their grieving experience. Van der Heijden et al. (2010) conducted a study on South African children from impoverished communities who attended an intervention programme which provided psychosocial support and HIV-prevention education, including methods for dealing with grief and bereavement. They note that parental loss-related anxiety was primarily 'outward-focused – on social and economic conditions rather than on effects in internal conditions, such as depression or low self-esteem' (p. 45). Orphaned participants were worried about having no financial means, felt they were vulnerable for abuse, were concerned they were not allowed to continue their schooling, or were worried they had to neglect schoolwork due to increased household tasks (*ibid.*). Van der Heijden et al. (2010) conclude that the descriptions of their participant's experiences of grief 'demonstrate the immense influence that environmental and social factors have on children's fear and anxiety, loss and loneliness'(*ibid.*).

However, non-orphaned children might face similar socioeconomic insecurities. In the study of Van der Heijden et al. (2010) the worries that were voiced by children whose parents had died or were in the process of dying, were

also found amongst children whose parents were absent through divorce or desertion (p. 45). Many children experience poverty in Namibia. Furthermore, a larger number of Namibian children do not live with both parents under the same roof. Roughly 25% of Namibian children live with both parents, and just over a third of Namibian children do not live with either parent (NPC, 2010, p. 41). Studies on the effects of becoming orphaned in a context of HIV and AIDS in sub-Saharan African countries do not show a consistent picture on whether orphaned children are more disadvantaged than non-orphaned children in these circumstances.

A mixed picture of the effects of orphaning

Adversities in the lives of orphans growing up in a context of HIV/AIDS in sub-Saharan Africa have been well documented, such as school non-attendance, poor schooling outcomes, diminished access to food, health care, clothing, housing and sanitation, stigmatisation, homelessness, a high risk of exploitation, abuse, family conflicts and emotional problems (Booysen & Arntz, 2002; Bicego, Rutstein & Johnson, 2003; Case & Ardington, 2006; Nyambedha, Wandibba & Aagaard-Hansen, 2003; Shetty & Powell, 2003; Cluver, Gardner & Operario, 2007; Harms, Jack, Ssebunnya & Kizza, 2010; Morantz et al., 2013). A number of the orphaned adolescent participants of this study, who initially participated as children in my 2003-2004 study, experienced food insecurity as a child which caused concentration problems in school, a high workload in their household and bullying by fellow learners (Van der Brug, 2007). Mushaandja and Ashton (2013) found a severe level of food insecurity, mistreatment at home and limited access to education amongst orphans in the in Namibia's capital Windhoek.

Various studies have found that such difficulties are clear consequences of orphaning. Ruiz-Casares, Thombs and Rousseau (2009), in their study of 157 Namibian orphaned and non-orphaned children and teenagers, reported that orphans, and particularly double orphans, are vulnerable to elevated symptoms of depression. 'Disruption in family functioning, socio-economic deprivation, and lack of supportive services may partly explain the burden of child and adolescent mental health,' they state (p. 273). Cluver et al. (2007) found that AIDS-orphaned children in South Africa had higher overall levels of psychological difficulties and peer relationship problems than both children orphaned by other causes and non-

orphaned children. Based on a longitudinal survey in South Africa, Bozzoli (2010) reported that female orphans are at a higher risk of becoming teenage mothers than non-orphaned women. A literature review found that social and psychological functioning, educational achievement and the economic wellbeing of children orphaned by AIDS were worse off than that of non-orphans (Earls, Raviola & Carlson, 2008).

However, other studies reported no significant differences in outcomes of orphans compared to non-orphans. Although Bicego et al. (2003) found in their analysis of the Demographic and Health Survey from various sub-Saharan African countries that losing one or both parents to AIDS diminished the chances of children being at the appropriate grade level for their age, they also report that 'The findings suggest that, from a purely economic standpoint, orphans are not more disadvantageously situated than non-orphans' (p. 1242). Hereby they note that this finding does not give information on the intra-household allocation of resources (p. 1242); such issues are discussed in the next chapter. In a study on children in deprived settlements in Cape Town, Cluver and Gardner (2006) found little evidence for differences in psychosocial wellbeing between orphaned and non-orphaned children. Based on the data from a longitudinal cohort study in KwaZulu-Natal, South Africa, Parikh et al. (2007) explored 'the Cinderella myth'. In this study, no statistically significant differences were found in most education, health and labour outcomes between orphans and the non-orphans with whom they live (p. S95). Parikh et al. describe that the orphans in the sample lived with close relatives (aunt or grandmother) or with their surviving parent, and are therefore likely to receive the same support as the non-orphans with whom they live (p. S101).

Sherr et al. (2008) undertook a systematic review of literature on the effects of orphanhood on outcome measures, most notably psychologically and physically, in various African countries and in the USA. Although they found a consistent picture of negative effects of parental death on diverse physical, socio-economic and psychological outcomes, a detailed analysis showed a mixed picture whereby alongside negative effects, effects of no differences were often found. Only a few studies that were part of the review explored protective factors; the factors that were found seemed to be associated with family provision, quality of care and economic assistance. The authors note that the blurring of definitions, the lack of consistent measures and the lack of differentiating between orphan

subgroups (paternal, maternal, double, AIDS) are obstacles in comparing studies on effects of orphaning (Sherr et al., 2008)

Criticism on the focus on adversities of orphans

Various scholars have criticised the focus on adversities of AIDS-related orphanhood within academic research, policy and interventions, as it does not adequately address childhood poverty in sub-Saharan Africa. Scholars writing about southern Africa have argued that highlighting the vulnerabilities of AIDS orphans obscures the ways in which they share similar circumstances with other poor children (Henderson, 2006, p. 303), and that other children whose vulnerability is similarly increased in the context of the AIDS epidemic are side-lined (Meintjes & Giese, 2006, p. 425). Crivello and Chuta (2012) note: 'The attention given to orphans in the international child protection discourse suggests that orphanhood is a major, if not *the* major factor affecting child vulnerability in sub-Saharan Africa' (p. 537). Although most aid organisations and governments refer to 'orphans and (other) vulnerable children' (OVC), Crivello and Chuta (2012) argue that 'the very concept of OVC illustrates the tension that exists between targeting specific groups of children for support – such as orphans – and developing strategies for addressing child vulnerability more generally' (p. 537). As a result, responses to vulnerable children in Namibia increasingly shift from 'HIV-affected and otherwise vulnerable' to 'poverty-affected and otherwise vulnerable' (UNICEF, 2013: xvi).

Ansell (2016) states that although the association between AIDS-related orphanhood and disadvantage is questionable, the continuing emphasis on this group of children is influenced by various factors. Amongst others, orphanhood is concerning to Western society due to the common sense expectations about the concept; such as that nuclear families are 'natural' milieus for child rearing or that orphanhood is a significant marker of disadvantage (Ansell, 2016, p. 167). However, these phenomena do not necessary translate globally as in many societies children are raised in extended families with various relatives participating in parenting (*ibid.*). Besides, as Bray (2004, p. 52) and Meintjes et al (2006, p. 408) argue, the AIDS orphan has become the 'quintessential vulnerable child' like other groups of children such as street children, trafficked children and child soldiers, and this image gives reason for action and mobilises funding.

Ansell (2016, p. 168) further states that children affected by AIDS are attractive for funding as 'donors, NGOs and governments are generally happy to be associated with child-saving'. Cheney (2010) points out that in order to secure financial backing, much work with children in Africa is reframed as work with OVC.

Intervening factors

Govender, Reardon, Quilan and George (2014) note that more recent studies question whether orphanhood is the primary variable related to the material and psychosocial outcomes. For instance, a review of 60 nationally representative household surveys from 36 different countries – mostly sub-Saharan African – found that orphanhood and co-residence with a chronically ill or HIV-positive adult are not universally robust measures of child vulnerability (Akwara et al., 2010). Instead, they posture that household wealth should be seen as a key predictor of child vulnerability (*ibid*). Govender et al. (2014) similarly found in their longitudinal study that socioeconomic factors (household, poverty and caregiver characteristics) and indicators of psychosocial wellbeing did not differ significantly between orphans and non-orphans in South Africa. Furthermore, children's psychosocial outcomes were more strongly influenced by household composition and size, living above or below the poverty threshold, and the quality of care factors such as the caregiver-child relationship and caregiver's health (*ibid*.). The authors argue that these results provide evidence for 'moving beyond narrow definitions of vulnerability associated exclusively with orphanhood to consider the multitude of material, social and relational factors affecting the psycho-social wellbeing of children in general who are living in circumstances of poverty and HIV and AIDS' (p. 1).

In short, there is no consistency in findings on the differences between the socioeconomic insecurities of orphaned and non-orphaned children living in contexts of poverty and HIV/AIDS in sub-Saharan Africa. It is likely that intervening factors such as household wealth are more decisive than orphaning per se. What is clear, is that both poverty and the HIV epidemic can have a range of adverse consequences on orphaned and non-orphaned children's lives. The HIV epidemic not only has an effect on households directly 'affected' by illness and death, but also on communities in general, for instance as extended families take in orphaned children (Booysen & Arntz, 2002, p. 180). Children living in poor

or severely impoverished households are already vulnerable, HIV and AIDS add to such difficulties when parents, breadwinners or caregivers feel unwell or die due to AIDS (NPC, 2010, p. 74). Orphaned children may experience the loss of protection from their parents and miss a sense of belonging. These diverse socio-economic insecurities that orphaned children may experience can play a role in how orphans comprehend grief and respond to bereavement after parental loss, as the findings of my study show.

5.2 RESEARCH FINDINGS

The findings describe the relation between the loss of a parent and the loss of economic security. It shows that orphans often express the loss of their parents in terms of a lack of material and financial assistance. The findings also describe how orphans perceive their own economic situation in comparison to non-orphaned peers. The state tries to improve orphans' economic security through social protection measures, of which the child welfare grant is the most important. This grant has a positive effect on the economic wellbeing of orphans and their households. This research shows, however, that a substantial part of the orphaned participants did *not* benefit from this grant, even though they qualified for it. Furthermore, the usage of the orphan grant for household costs sometimes led to conflicts between orphans and caregivers.

5.2.1 The meaning of parental loss: the loss of material and financial assistance

A number of the orphans felt that, with the loss of their parent, they had lost financial and material security and assistance that their deceased parent could have provided. Often, when orphans were in need of such assistance, they were 'thinking about' and thus reminded about their late parents. As has been described in Chapter 3, 'thinking about' a deceased parent might be considered, in the context of this study, as part of the bereavement process as participants perceived it as negative and emotional and associated it with the (unexpected) absence of the person in their life.

The meaning of the deceased parent in the life of the child, with the parent as a provider, is thus a central aspect of these children's experiences of bereavement and loss. Neimeyer et al. (2010) stress the need for meaning-making processes in understanding grief, by noting that losses can 'challenge the fundamental conditions that sustain one's actual lived experience, undercutting one's broad sense of meaning and coherence' (p. 74). Questions like 'What did this person mean to me?' and 'What does this person's death mean to me?' are essential in the resolution of grief (Klass, 1999, p. 163). The lost relationship is hereby often emphasised, Jakoby argues (p. 687). Jakoby (2012) writes: 'The sociological concept of *threads of connectedness* (Lofland, 1985) best describes the multidimensional connections that are destroyed by death. Understanding grief socially means that we have to understand the social bond between the deceased and the survivor and the variation in significance that others may have for us. We are linked to others by the roles we play, the support we receive, the wider networks others make available to us, the selves others create and sustain, the reality they validate or the future they make possible for us' (p. 687; see Lofland, 1985, p. 175). Thus, grieving for what had been expected of the person of hoped for is part of bereavement (Field, Hart & Horowitz, 2009, p. 408). Such issues may also relate to the survivor's loss of status after a significant other has died; from the perspective of structural theory, deaths of important others may represent the loss of status, especially love and support (Jakoby, 2012).

Some orphans had expected or hoped that their deceased parent would have provided basic necessities. Child orphans mostly mentioned clothes, and the payment of their school fees. For instance, Martin was reminded about his father when his clothes were torn, he commented: 'When my shirt is torn, I just start to think that my father could buy clothes for me'. In letters to their deceased parent (a research method which is described in Chapter 2), some of the orphaned children wrote about the material support that their parent could have provided. For instance, Martin wrote: 'Father, I want you to buy me clothes which I would wear at home, I also want to go out with you and I want you to pay for my school fees'. Hango similarly wrote: 'If my father was alive he would buy me clothes and food.'

This emphasis on the loss of material and financial assistance after the death of a loved one did not appear similarly clear in the stories of non-orphaned children. Most of the non-orphaned children who wrote a letter to a deceased

family member mentioned instead that they missed the person. One girl, Savalia, also wrote about the way her grandmother supported and helped her: 'I want to tell you how you loved me, when you loved me grandmother, I am praising you, you used to give me food, bought me clothes and shoes and you used to cook for me. You were bringing me up and you used to wash me, I am praising you, grandmother'.

Adolescent orphans similarly felt that their late parents would have assisted them financially and materially. Claudia, a single orphan, missed the financial assistance of her father which he had provided before his death. She recalled:

> I lost my father. That time [the period after his death] I was not feeling good because I was used to the support of my father: paying for my school fees, buying me school needs like shoes, a school bag and many more things.

She noted that when her father was remembered within the family, they talked about how he used to financially assist them. She would feel bad when friends discussed new school uniforms, as her father had been the one to buy her one. She noted: 'When I am with my friends and they talk about what their parents bought for them, I say if my father was alive I would have what I need now'. After his death, she stayed with various relatives as her mother could not provide for her. She often had to think about her my father when she had to ask her caregiver or other relatives for school fees and books, as she often would not receive the support or it would take long.

Samuel, a double orphan who dropped out of school, remained unemployed at home during 2010. According to his aunt, he was depressed about his situation and spent long periods of time in his hut. His lack of money for any essentials such as clothes or soap often made him think about his parents' death. He commented: 'I think about my parents when at home I use someone's lotion or soap and the person shouts at me'. Samuel also expressed his grief about the death of his grandmother, who took care of him after his parents died, in terms of the loss of financial support. He commented:

> When it is time to collect the pension, I think of my grandmother because when she used to get her pension she used to buy me shoes and she would also give me some money to buy food at school. And the time

> when I first came to secondary school and there was no-one to pay for my school fees, there I would start to think about her.

The loss of financial assistance may also lead to social insecurities. As children, the adolescents had endured remarks from peers about their lack of support and their poor appearance. Foibe noted: 'They used to say things like my father is dead and that I do not get supported'. Justin remembered: 'They would laugh at me saying why I was wearing bad and torn clothes'. Teachers confirmed that children were teased at school for wearing torn or old school uniforms. Nelao commented that, although she was often ashamed about her appearance as a child, she accepted her situation: 'I just accepted that my parents are dead, so I did not cry and want to have things which kids who have parents had. [...] I know my parents are dead and there is no one who can buy those things for me.' Thus, financial and social insecurities are often interrelated.

5.2.2 Shattered dreams

A number of orphans felt their parents would have provided them with relatively luxury articles or that their financial assistance would have helped them to achieve more in life. Such feelings of loss of opportunities or special support might be viewed as a kind of grief that Bowman (1999) calls 'shattered dreams'. He defines shattered dreams as 'the loss of an emotionally important image of oneself, one's family, or one's situation; the loss of what might have been; abandonment of plans for a particular future; the dying of dreams' (p. 181). Bowman based this concept on the ideas of Lester (1995), who wrote that 'much of bereavement can be thought of as the interruption or loss of the future story' (Lester, 1995 in Bowman, 1999, p. 181). Loss is thus not only a past event (Bowman, 1999, p. 186), but might similarly be present in expectations about the future. Gross (2018) describes how the shattering of dreams can be viewed as a symbolic consequence of loss. He notes: 'implicitly, and/or explicitly, every attachment is *future-orientated*: there are shared hopes and expectations regarding what lies ahead for the relationship. The death of one of them immediately and fundamentally shatters these hopes and plans (p .4).

Figure 5-1: 'If my parents were alive, they would buy me a bicycle' (Festus)

Figure 5-2: 'If my father was alive, my birthday would be celebrated' (Hango)

Some child orphans imagined their late parent would have given them a bicycle (see Figure 5-1), which only a few of the children in the village possessed, or that their birthday would be celebrated (see Figure 5-2), which was only common amongst wealthier families. Frieda thought her father would have taken her to school by car, although practically none of her fellow learners went to school by car. A few adolescent orphans felt they missed out on chances in life. For instance, Justin, a double orphan who dropped out of school and worked at a garage, thought his parents could have financed his studies at an institution for out-of-school youths so that he could finish his education. The double orphan Samuel felt that his life would have been easier with financial support from his parents, instead of having to turn to family members. Orphans were also reminded about their misfortune, when they compared themselves with non-orphaned learners who were financially supported by their parents. For instance, Alex did not experience basic financial insecurities but missed his father's support when he compared himself. In the excerpt below, he described such feelings of loss:

> It does not feel good to see someone with a father, and there you are without a father. It brings some feelings which are not good, yes, there is a big difference because that person has support from his mother and father but me I depend only on my mother, which is the problem. And if you had your father then the thing would be better. Like now I am at the tertiary institution, I cannot go into the hostel because it is very expensive. You know when you are at tertiary institution, you need to be equipped, you need more, like a laptop, and laptops are very expensive but others can afford them.

Such examples of a perceived lack of economic security are in line with the notion of 'relative poverty' (Thomas, 2000). Thomas (2000) argues that what is regarded as poverty may differ relative to norms and value systems of each particular society (p. 12). Relative poverty pertain to the lack of resources to participate in activities and have the living conditions which are customary in a society; or when an individual's resources are so seriously below the average individual or family that they are excluded from ordinary living patterns and activities (Thomas, 2000, p. 12, 13). Relative poverty can also be about lack of choice or capability rather than simply just living standards (Thomas, 2000, p. 14), such as Justin' lack of choice concerning continuing his studies.

5.2.3 Comparing orphans and non-orphans

Understanding how orphans perceived their economic situation gives us further insights into the relation between grief and a reduced economic security. What kinds of support are orphans lacking due to parental death in comparison to non-orphans? How do orphans compare their own economic situation with the situation of non-orphans?

About half of the orphaned child participants perceived their economic situation as less favourable than non-orphans. They felt that non-orphans had nicer or newer clothes and school materials; they were taken to shops, and had better food security. For instance, they mentioned that non-orphans would eat every day, whilst they would not. Kagumbo, a double orphan, noted that watching children taking bread to school or having money to buy sweets, made him feel bad. He also emphasised individual differences between orphans in their access to food. When Martha, a single orphan, mentioned she always brought a lunch box to school, he responded: 'You Martha, you – you have your mother. Me, I do not have parents, there is nothing in my lunch box; it's clearly empty'. However, other orphaned children (about half of the group) perceived their economic situation as similar to that of non-orphans. Thus, these findings are in line with the argumentation described in the introduction of this chapter that orphanhood is not necessarily related to economic adversity.

In contrast to the child orphans, the majority of the orphaned adolescents perceived the economic situation of non-orphaned peers as better than their own. This is possibly due to the fact that most of them had not received an orphan grant when they were young, as at that time the child welfare grant system reached a small proportion of orphans, or because they were more conscious of the parental support they missed. They felt that non-orphaned peers were supported by their parents in providing them with new clothes, school materials and school uniforms.

The few adolescents who did not see a difference considered the support from home as sufficient, or took into account that their late parent had already not supported them before their death. They also reflected that such differences had been significant when they were a child – such as going to school bare foot, without having eaten, and not having sufficient clothes – but that as adolescents,

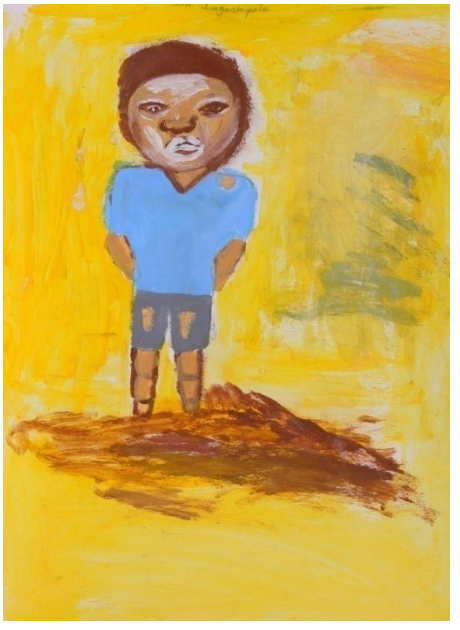

Figure 5-3: An orphan with torn clothes (Nothando)

Figure 5-4: An orphan without shoes (Berthilde)

Figure 5-5: An orphan thinking about his parents (Trevor)

Figure 5-6: Orphans are often sad (Tuilika)

these differences had been become less as they had now more opportunities to access support. For instance, Foibe, a single orphan, who had stayed with her aunt from a young age, stated: 'Now that I am bit grown up, I can go visit my mother and ask for help. My uncle who is in Walvis Bay also helps me now, and if I ask for something in the house, I can also be given it, because I am older now'.

Additionally, non-orphaned children were asked about their views on the economic situation of orphans. A number of them considered orphans to be poorer than themselves; for example, orphans did not bring lunch boxes to school. In their drawings, non-orphans predictably depicted orphans as children who received little financial support; wearing torn clothes (Figure 5-3), or having no shoes (Figure 5-4). Nothando said about her drawing (Figure 5-3): 'This child does not have parents. She has torn clothes because no one is buying her clothes'. They also depicted them as children who were thinking a lot about their late parent (Figure 5-5) and who were often sad (Figure 5-6). Campbell, Skovdal, Mupambireyi and Gregson (2010) found that drawings as a research technique may encourage stereotypical representations of AIDS-affected children. Although in the current study non-orphans depicted orphans stereotypically in the drawings, these orphans were known to them; they had made a drawing about a neighbouring child, a friend, or a child from their household. In contrast, other non-orphans felt that orphans were in a better economic position due to the orphan grant they received. Thus, this seems an indication that child grants contribute to the economic security of orphans. For instance, non-orphans noted that orphans were bought new clothes or a school bag whilst they themselves did not receive such items. Frieda commented: 'If something is bought in the house, it would only be given to orphans. Like shoes and clothes'.

5.2.4 Support and strategies to restore economic security

Child welfare grants and other state provided support

In Namibia, the child welfare grant system is a crucial policy tool to increase economic security amongst orphaned children. Child grants are one of the social protection mechanisms in Namibia, whereby social protection is understood as: 'a set of public and private policies and programmes undertaken by societies in response to various contingencies in order to offset the absence or substantial reduction of income from work; provide assistance to families with children; and provide people with health care and housing' (United Nations [UN], 2000: 3). The grants were designed to mainly support the growing group of children who became orphaned through AIDS (NPC, 2010). The number of recipients of child welfare grants increased rapidly in Namibia – from 9,000 in 2002 to 181,033 in 2015 (UNICEF, 2015a).

Child welfare grants include four different cash transfers for orphans and vulnerable children, of which the maintenance grant and foster care grant are most common (NPC, 2010). Both grants have a value of N$ 200[11] per month. Child Maintenance Grants (CMG) are paid to a biological parent of a child who is under 18 years (or 21 if in full-time education) and whose spouse is 1) receiving an old age or disability grant, 2) has died or 3) is in prison, and the grant is implicitly conditional on a child's school attendance (NPC, 2010). The grant is means-tested with an income threshold of N$ 1000 per month. The Foster Care Grant (FCG) is paid to any person who undertakes the temporary care of a child that has been placed in his or her custody, and is also conditional on a child's school attendance, but not means-tested (NPC, 2010). In the region where this research took place, the majority of caregivers with a child in their custody were maternal grandmothers and aunts (interview: social worker, 2012, Ongwediva)

Increasingly, this child welfare system is criticised for having a limited impact on general child poverty rates. The grants are mainly allotted to orphaned children, while the wider group of children living in poverty are not reached (NPC, 2010). NPC (2010) reported that there is a minimal difference between the poverty rates for orphans (45.3%) and non-orphans (42.9%) (p. 15,29). On the contrary, an overview of poverty rates in the 2009/10 Namibia Household Income

[11] In mid-June, 2018 1 euro was worth 16.2 Namibian dollar.

Expenditure Survey (NHIES) showed a different picture, with poverty rates for households with orphaned and non-orphaned children accounting for 51.4% and 32.7% respectively, with the proportion in severe poverty comprising one-third of each cohort (NSA, 2012, Figure 10.2.4.17). Lydia Shikongo (Deputy Director of Child Allowance/ Child Care Services, interview: 2013, Windhoek) stated that vulnerable children within this system are not being reached enough: 'What we are covering now are mostly the orphans, and vulnerable children who are fostered. If the child is not fostered, even if they have nothing, there is no way you can assist them'.

Already in the early 2000s, Meintjes, Budlender, Giese and Johnson (2003) stated that the provision of a grant, primarily aimed at children whose parents have died, would be an inappropriate response to addressing children's socio-economic vulnerability in the context of the AIDS pandemic in South Africa, and proposed a universal child grant without a means test. In 2010, a report on the effectiveness of child welfare grants in Namibia recommended that the CMG should be adjusted to become a mean-tested grant for all poor and vulnerable children in the country (Ministry of Gender Equality and Child Welfare [MGECW], 2010). In 2015, adjustments to the Child Care and Protection Act were adopted to include a legal provision that allows for a gradual expansion of child grants in Namibia (UNICEF, 2015). Thus, there is a shift in focus from reducing attention on children vulnerable to AIDS to strengthening interventions for children affected by poverty in general (UNICEF, 2013, p. 52).

In order to support orphaned and vulnerable children, Namibia has also established school feeding programmes and an exemption of the payment of 'school fees' (school development-fund contributions) for child welfare grant recipients. However, a review showed that many schools still expected these children to pay school fees (MGECW, 2010). Another survey found that many children indicated that they often suffered due to an inability to pay for school-related expenses (NPC, 2010).

A considerable number of orphans are taken care of by grandparents or other elderly caregivers within the extended family. The Old Age Pension (OAP), received by these elderly caregivers, is a further resource which is used in the care of orphaned children. The OAP is a non-contributory social pension paid to all citizens or permanent residents who reach 60 years of age, irrespective of past and current employment status and income (Levine, Van der Berg and Yu, 2011). In

2008/2009 the value of the pension was N$ 450 (*ibid*.). OAPs appear to help the poor, particular the elderly and children (Case & Deaton, 1998; in Pelham, 2007). A 2012 study on social grants in Namibia for the MGECW and the NPC in Namibia found that OAPs, with 95% coverage, positively impacted upon child poverty, with 22% of children in poverty living in a household with a pensioner (MGECW and NPC, 2013, in UNICEF and Republic of Namibia, 2013).

Support received by participants: acquiring child grants and support from relatives

Amongst the child orphans, 8 out of 11 orphans received a child grant, or had received it in the past and were awaiting a continuation of the grant due to a change of caregivers. Table 5-1 provides an overview of the child grant recipients. In contrast to the mid-2000s, when many adolescent participants endured a long application process for the grant, the child orphans' application procedure had been uncomplicated for those who had the right documents, such as the birth certificate of the child, ID of the applicant, and the death certificate of the deceased parent. For instance, the mother of Frieda explained that she easily got the grant: 'It was not difficult to get the grant, I got it soon after I applied. It started in kindergarten, and it will end when she finishes her education'. Three child orphans did not receive a grant as they lacked the required documents.

Within the adolescent participants, 7 out of 11 orphans had received a child grant in the past, or received it now. Only Alex had received the grant since he was a child, since 2004. The majority of the adolescents had received the grant for only a few years, due to a long application process (sometimes as long as 5 years), due to caregiver and household changes, or the grant ended early because of school drop-out. For instance, Justin had only received a grant in grades 9 and 10, as the application process was long, and he dropped out of school after failing grade 10. Two adolescents, Meke and Grace, received a children's pension as their fathers had been employed as a civil servant. A children's pension is a monthly income benefit for minor children of a deceased member of the Government Institutions Pension Fund (GIPF). Meke's child pension was, however, discontinued, because – as she stated – her mother did not attend an appointment with the magistrate. Three adolescent orphans did not receive a grant, because they lacked the necessary documents, or, as in the case of Brigita, because their

caregiver had not applied for a grant. Brigita' caregiver– her great aunt –had probably not applied because she knew that Brigita' father, who was thought to have died, was actually alive; information which she withheld from Brigita for a long time (see Chapter 2). Her caregiver also did not apply after Brigita' mother died, as she was already in her last year of secondary school, and would afterwards join a nunnery.

Table 5-1a: Children receiving orphan grants and financial support from relatives

Child orphans				
Name	**Grant**	**Grant reaches child***	**Characteristics**	**Person(s) supporting the child**
Taiwo	Received in past	yes	Due to caregiver change, temporarily without grant	Aunt
Festus	No	-	Documents were not handed over	Grandmother, grandfather, children of grandfather, sister
Kagumbo	No	-	Documents are missing	Aunt
Liezel	yes	yes	-	Father
Erastus	yes	yes	Mother who resides elsewhere receives grant for Erastus	Grandmother, grandfather, mother
Hango	yes	no	Mother does not hand over money to caregiver	Grandfather, grandmother
Helena	yes	yes	-	Mother, grandmother, great aunt
Helvi	yes	yes	-	Mother, aunt
Martha	no	-	Documents are missing	Mother, aunt
Martin	yes	yes	-	Mother, aunt
Berthilde*	yes	yes	-	Mother, uncle

Note: This data reflects the perspective of the child or adolescent participant, or is based on information provided by the caregiver.
*Berthilde, initially part of the non-orphan group, is included in this overview as she turned out to be a single orphan during the research.

The child orphans benefitted from a school feeding programme, which had been in place since 2007. The teaching staff observed that the feeding programme, although irregular due to food supply problems, had positive effects on absenteeism and on the learners' performance, as their concentration improved. Furthermore, the school received sporadic donations for OVC learners, such as school uniforms. According to the principal, almost all orphaned learners paid their contributions to the school development fund. Orphans could apply for exemption at the School Board, but this was generally not requested. It seemed that caregivers and parents were somewhat pressured to pay for these 'school fees': the principal noted that they were asked to pay in kind (chicken, goats or cleaning the school) when they could not afford the fees.

Orphaned children and adolescents often received material and financial support from various extended family members. Table 5-1a and Table 5-1b give an overview of relatives that, according to the child, supported them. Generally the main caregiver was the main provider, such as a grandmother, remaining parent or aunt, while extra support came from other (residing) relatives. Below, three child orphans provided examples of the support they received from different relatives:

- Festus, double orphan, resides with grandparents: Grandmother (clothes, food for lunch box), grandfather (school fees), children of grandfather (clothes, umbrella), sister (soaps, lotion)
- Kagumbo, double orphan, resides with distant related relatives: Aunt (food, school fees)
- Erastus, single orphan, resides with his grandparents: Grandmother (hospital expenses), grandfather (food), mother (clothes)

Non-orphaned child participants similarly received support from extended family members. For instance, this occurred when they stayed in a household with various residing adult family members, or when they stayed with a foster caregiver and their biological parents did not contribute to the costs of their care. This latter group of children, together with children whose biological parents are alive but are not able to support them adequately, is considered a broad group of children who are missing out on child welfare grants (MGECW and NPC, 2013, in UNICEF and Republic of Namibia 2013).

Table 5-1b: Adolescents receiving orphan grants and financial support from relatives

Adolescent orphans				
Name	**Grant**	**Grant reaches child***	**Characteristics**	**Person(s) supporting the child**
Samuel	Received in past	no	Aunt used the grant for herself	Grandmother before she died, aunt
Justin	Received in past	yes	-	Grandmother, aunt
Petrina	no	-	Problems with application	Grandmother
Nelao	Received in past	yes	Household and caregiver changes	Grandmother, sister
Grace	child pension	partly	Guardian keeps the pension for herself	Grandmother
Brigita	no	-	Did not apply for grant	Grandmother
Alex	yes	yes	-	Mother, grandmother
Meke	child pension	yes	Pension ended in 2012	Mother, grandmother, great grandmother
Claudia	no	-	Documents were not handed over	Mother
Foibe	yes	partly	Mother does not hand over full amount to caregiver	Uncle, aunt
Hilma	yes	yes	-	Great aunt

Note: This data reflects the perspective of the child or adolescent participant, or is based on information provided by the caregiver.

Orphans generally perceived the support from extended family members as more conditional than that from biological parents. Various adolescent orphans stated that biological parents' support was given out of love, while provisions from extended family members as given out of social pressure. Therefore, child orphans often found it difficult to ask for financial or material help. For instance, Martha did not ask her aunt for help: 'I do not ask, I would be afraid she would say she doesn't have money'. The system of support from the extended family has a reciprocal character; young people are expected to provide for their relatives when they earn an income. The orphans in this study seemed to want to meet those expectations. They hoped to financially support their caregivers, siblings and other relatives in the future, and adolescents who were employed already

assisted their family. Thomas (2006) found that in the Caprivi region of north-west Namibia the role of orphans in contributing to reciprocal support networks emerged as a key factor in their 'adoption' (p. 3187).

The majority of deceased parents of the participants had not made financial plans for their children, except for the child pensions from Grace and Meke. Furthermore, various caregivers, especially grandmothers, noted that the remaining father of maternal orphans often did not support the child financially. The three teen mother participants of this study similarly complained that the father of their child refrained from contributing to the costs of their child's care. Although one of them, Nelao, planned to start a court case against her former boyfriend in order for him to start contributing, most of the grandmothers were hesitant to report fathers as they feared this would withhold the father from supporting the child in the future.

Positive effects of child grants

Child grants made an important contribution to families. In households that consisted of nuclear families headed by a remaining parent, child grants were sometimes the only source of income. For instance, the mother of Martin noted: 'All my children receive an orphan grant. The money is helping with household needs, the field, and we also pay for water from the grant money'. Adolescents remembered that the grant helped their caregivers to pay for their school uniforms and school fees. For example, Justin noted that before he received the grant, his grandmother always had to sell a part of the harvest in order to buy his school uniform or clothes. Alex similarly remembered:

> At that time [2003], there were problems. It was difficult for our mother to afford things like clothes. Our mother was always stressed because of school fees, and we were three, all of us going to school. I think it has changed because the government has introduced an organisation for orphans. My mother keeps the money for us and buys clothes and pays our school fees.

A 2010 review of child welfare grants in Namibia found that grants are mainly spent on food, beverages and education, especially school fees; whereas the money goes to children's clothing, housing costs and child health fees to a lesser extent (MGECW, 2010, p. 32; NPC, 2010). In this study, some children indicated that the grant money was mainly used for their needs. One mother remarked that

her daughter did not accept clothing from cheap shops anymore since she received the child grant. Other orphans indicated that the grants were used for general household costs as well. For instance, Hilma noted: 'The money is used for me and the household members. My needs are met first, so the remaining can be for them.'

Levine et al (2011) conclude that cash transfers in Namibia, such as the child grant, have a critical role in alleviating poverty, especially for the very poor. They remark: 'The poverty reducing effects of the child grants are likely to increase further as access is being rapidly expanded. However, the impact in terms of reducing Namibia's extremely high inequality is limited' (p. 39). In other African countries, cash transfers also have positive effects on children's wellbeing. A study in Kenya found that children and adolescents in households receiving the regular (unconditional) government-supported 'Cash Transfer to Orphans and Vulnerable Children' (CT-OVC), appeared to 'have better nutritional status, school attendance, and optimism about the future, compared to those in households not receiving the CT-OVC, in spite of some evidence of continued material deprivation' (Ayuku et al., 2014, p. 12).

In my study, the school staff noted that the orphan grant had helped learners to do well at school; they observed a similar school performance of both orphaned and non-orphaned learners. Although they partly attributed this lack of difference to the fact that many orphans had lived with their grandparents before their parents died and in that sense did not differ much from non-orphans, they also felt that it was a combined result of the school feeding programme and the child grant.

Not profiting from child grants

About half of the orphaned participants did not (fully) benefit from the child grant. This was due to two reasons: orphans did not have the documents needed to apply for a grant, or the money did not reach them (see Table 5-1a and Table 5-1b for an overview). A 2013 study of social grants in Namibia found that children who qualify but don't receive grants, including children without birth certificates, are a broad group of children who are missing out on this financial support (MGECW and NPC, 2013, in UNICEF and Republic of Namibia, 2013).

Thus, not all orphans profit from the financial security that the state tries to offer through the child grant system.

Missing documents

Some caregivers did not have access to the death certificates of the deceased parents of children under their care due to several reasons. For example, caregivers were often not in contact with relatives of the late parents, or with the remaining father. Grandmothers in particular complained during interviews that they could not trace the father of their grandchildren after their daughter had died, and were thus unable to receive a grant as the remaining parent had to apply. The high rates of relationships in which partners do not live together amongst the Ovambo (Tersbøl, 2002) seem to be related to this lack of contact. For instance, Martha's aunt did not have access to her late father's certificates as Martha's father had left her mother when she was pregnant and had not stayed in contact; they only heard that he had died. Martha was taken care of by her aunt as her mother was not able to do so. Towards the end of the research period, relatives of Martha's father had searched for Martha, and promised to bring his death certificate. Contact with relatives was also lost when all close relatives of the orphan had died. For instance, the distant relatives of Kagumbo who took care of him could not approach any of his close relatives for the missing death certificates of his parents, as they all had died.

Documents were misplaced as well. The caregivers of the adolescent Petrina, a double orphan, had applied for a grant when she was young, but experienced that the procedure took very long. Petrina herself noted that the required documents of her father had been lost. Finally, the caregivers had given up on applying, stating: 'We have been waiting in vain. It is just a waste of money on transport'.

In other cases, documents were deliberately not handed over by relatives of the late parents to the caregiver of the orphan. For example when these relatives were planning to take the orphan in themselves in order to receive the orphan grant. Thus, due to the child grant orphans might be viewed as an asset instead of a burden. The case of Festus is an example of such a situation. The boy, a double orphan, had already been taken care of by a paternal great-aunt for years. The maternal family of Festus was not supporting him. His great-aunt noted that other

paternal relatives refused to hand over the death certificate of his father, so that she could not apply for a child grant. She suspected they were planning to take in Festus:

> Festus does not receive a grant, I kept asking the family of his father to bring the document they are keeping but they do not want to. [...] Now they came to take his school report when they took him for holiday, I am assuming that maybe they want to have him start school there. Even when his father passed away they wanted to run away with him but the mother of his father said, it cannot be that way. [...] They already have the death certificate of the father. Maybe they want to register him for an orphan grant, so the grant can go through them.

Social workers had to prevent the situation that children would only be taken in for their grant by examining the placement of a child under foster care, and involving the child in the decision (interview: Mrs. Kendetu, Deputy Director of Civil Registration, 2012, Windhoek).

Sometimes the documents could not be accessed as they were inherited by relatives. For instance, the father of Claudia, an adolescent orphan, had left his ID and birth certificate to his maternal relatives, making it impossible for Claudia to apply for a child grant. The inheriting of the possessions of a deceased husband by his relatives, and not by the widow or his children is a part of Ovambo 'customary law' of inheritance (Becker, 2005). The fact that her father did not leave his documents to his children, puzzled Claudia. She stated:

> I want to know about the type of behaviour he had, because apparently at the time he was sick, although my mother was there, he distributed up his possessions to his family members. I was very young, around the age of six or seven. He gave away cattle and goats and some of the things in the house like cupboards and chairs. He had a will that his relatives would come get those things when he died, just as his birth certificate and an ID. People would pick up or collect these things saying that it is already written that they would get them. If we knew who keeps his birth certificate and ID, we could go ask them so that we can get that orphan support.

In his well-known exposition on 'the cultural biography of things', Kopytoff (1986) draws attention to the social life of objects: not only do people have multiple biographies but similarly objects could be viewed from a perspective that they offer economic, social or technical biographies (p. 68). When documents are viewed from such a standpoint, Kopytoff's notion of the singularisation of objects and things, as the opposite of commoditisation, is useful. In the case of child

grants, documents are the objects which offer access to these grants; the singularity of these documents makes them valuable and cause for withholding them, or taking them up in a will. As is described below, one of the government's solutions to missing documents in grant application procedures is the duplication of documents; thereby thus discontinuing its singularisation.

Certain documents were also used to exert pressure, such as the school progress form. This form is part of the monitoring of the child grant; the caregiver has to prove that a child is in school through this form (interview: Mr. Nuuyoma, Head of social welfare allowance, 2012, Ongwediva). The report is to be filled in by the orphan's schoolteacher. During interviews, teachers noted that they sometimes used the form to pressure caregivers to improve the care for the orphaned child. Although this use of the school progress form was not known by the head offices of the MGECW (interview: Mrs. Shikongo, Deputy director Child Allowance, 2013, Windhoek); a regional officer of the MGECW expressed that they advise teachers to not fill in the form in case the child was not well taken care of. For instance, a teacher mentioned she used the school progress form to pressure caregivers to buy a school uniform:

> There are cases where I would tell parents or caretakers that they should buy a jersey for the student because it is cold. We refuse to have some of those forms signed until they buy a school uniform for the children. That is the only way to make them change, they know that the student must have a proper school uniform and the school fund must be paid.

When documents were missing, elderly caregivers in particular had difficulties finding their way through the application procedures. Orphans depending on elderly caregivers were thus vulnerable to being denied access to child grants, which contributed to their economic insecurity. Albertina Ndengu (Deputy Regional Counsellor, interview 2012, Ongwediva district) noted that elderly caregivers were also more often discouraged by the way they were treated during application trajectories in government agencies than younger caregivers, and therefore gave up on applying. For instance, the aunt of Berthilde, a single orphan who stayed with her grandmother, remarked that it had taken four years before the orphan grant was finally allocated, as the grandmother was not equipped to handle the procedure:

> You know, to stay with an old person is sometimes difficult because she does not go to follow up on things, she would only be sitting around the

> radio listening, until someone comes to tell her: go find out from the office.

Deputy directors and regional officers from the MGECW mentioned various solutions to handling missing documents for child grant applications. An absent death certificate of a parent (a Namibian citizen) who had died abroad could be replaced by a letter from the village leader where the person had been living or was buried. The Emergency Fund was in place for orphans who were in need of assistance but did not receive a child grant, through which food and clothes can be bought for the child. In the case of relatives refusing to hand over death or birth certificates, different strategies were used. These relatives were called in to the regional department of the MGECW to convince them to hand over the documents; village leaders, counsellors or church leaders were involved; or the documents were duplicated by the Ministry of Home Affairs and Immigration (MHAI). When documents went missing due to damage, the MHAI could, with the use of finger prints, provide new documents. Furthermore, birth registration has undergone improvements since the 2006 coverage rate of 67% (UNICEF, 2013, p. 103), so an increasing number of children now have birth certificates.

Child grant does not reach the orphan

The child grant did not reach the orphan in two instances: 1) when caregivers used the money for their own expenses, or 2) when the child did not live with the recipient of the grant (for instance the remaining parent) and the money was not handed over to the child's caregiver.

Some caregivers appeared to use the grant money for their own expenses. For instance, the aunt of the double orphaned adolescent Samuel was his legal guardian and received his child grant during the time that he was in schooling. Samuel complained she had used the grant for her own expenses: 'She was using it as her salary'. He remembered she paid his school fees, but did not buy him a school uniform or food. Later on the costs of the school fees were even taken over by his uncle. Samuel did not ask for the money, as he had decided to leave it. He stated: 'My aunt appeared to love me but it was not true, it was just because of the money she received for me'. After he had dropped out of school, the grant stopped and the aunt started to shout at Samuel and 'insult' him. Only when he started working, and bringing money home, he experienced that his aunt treated him better again. Also Emilia, a non-orphaned adolescent, received a social grant

as her father was disabled. She, however, noted that her father used her grant money, as well as his own disability grant for his own expenses and his girlfriend, not for his wife and children. She said: 'The grant money does not do anything to help around the house. He leaves when he has money because he has another woman outside the house. When he gets his money, he buys things like meat and sausages and nice things and leaves them in another room. On days that he goes to his other woman, he starts shouting and tries to beat us. […] When I ask for the money he gets angry.' Emilia realised that there was nothing she could do about it, and relied on the help from her sister and her aunt for her schooling.

In other cases the child did not live with the recipient of the grant, and the money was only partly or not at all handed over to the child's caregiver. UNICEF (2015) similarly makes note of the fact that many children who could benefit from the child grant do not because they do not live with the recipient of the grant. For example, the aunt of the double orphaned adolescent Grace took Grace's child pension for years. After the death of her parents in the year 2000/2001, Grace's grandmother had moved in with Grace and her siblings to take care of them. Grace's aunt received the children's child pensions, and used to hand it over to their grandmother. Increasingly, however, this would not happen. The grandmother depended on the money to run the household, as she did not receive an old-age pension as she lost her ID when a hut burned down, and did not manage to get a duplicate. In years with a bad harvest she used the child pension to buy food, with no money left for school materials and uniforms. After the grandmother moved out of the house, Grace had to run the household herself. Grace suspected her aunt would give her money: 'My aunt already knows that she has a responsibility… she will bring money or buy food.' However, Grace's aunt told her the child pension had stopped, and only gave her smalls amounts of money sporadically. The children had difficulties growing sufficient crop, and were often hungry. Grace worked in the fields of neighbouring houses in exchange for millet. A year and a half later, Grace attended a course at a nunnery, as she had plans to become a nun. One of the nuns had taken up Grace's case, and found out that the child pension not stopped, but that the aunt had kept the money herself. The nun pressured the aunt to hand over the money to Grace, after which she started to do so. Thus, it seems that orphans like Grace are vulnerable for grant misuse as they miss the protection from their late parents, which contributes to their economic insecurity.

Remaining parents who received the grant for their child did also not always hand over the money to the caregiver the child resided with. A regional counsellor officer observed that many remaining mothers 'dropped' their children with elderly relatives, using the child grant for their own expenses, while the elderly caregiver had to support the child from her old-age pension. For instance, Hango was fostered by his great-aunt while his mother, who resided elsewhere, received his grant. The great-aunt stated:

> His mother keeps the money which is meant for her child, but I am the one who is taking care of him. I am not even asking for that money, I just keep quiet. Never would I ask her. If his lotion and soap is finished I would just go and buy it from my pocket.

The mother of Foibe, a single orphaned adolescent, similarly did not, or only partly hand over the money to Foibe's caregiver, her aunt. Foibe has stayed with her aunt from a young age. The aunt remarked: 'Her mother keeps the grant money. Foibe gets some, but it is only when I ask or tell her mother that she needs shoes or to pay for the school fees'. Foibe herself, however, thought her mother handed over the full grant to her aunt. She also felt her aunt was mostly using the grant money for general household costs, and was therefore upset when she was told that the money was not sufficient for her needs. Foibe stated: 'Sometimes I would ask for body cream or school materials and she would scream or shout to me saying that my mother is the one that receives my grant money'. A year later, Foibe however realised that her mother had not been visiting her for a long time, and that she might not always hand over the grant. The reasons of surviving parents for not handing over grant money has not been examined in this study, but can be due to economic uncertainties in the parent's situation.

The Namibian government initiated regulations to prevent misuse of the orphan grant by caregivers, as was mentioned by regional officers and officers from the head departments of the involved ministries. School principals, village leaders, and counsellors had to inform the MGECW when they suspected misuse of the child grant. Furthermore, ministry officials advised that children should report misuse of their grant. In practice, however, as an officer of the regional counsellor stated, children refrained from reporting to official boards; only the village leader had dealt with a few cases of children reporting the misuse of their grant by their caregiver. Furthermore, representatives of the MGECW attended community meetings to inform caregivers about the usage and purpose of the

child grant. After receiving a report on the misuse of the orphan grant, the caregiver would mostly be talked to and informed about the right way to use the grant (interview: Mrs. Shikongo, 2013, Windhoek). Furthermore, in the grant application process, the school had to confirm that the child resides with the person applying for the grant to prevent not handing over the grant to the wrong person (interview: Mr. Nuuyoma, 2012, Ongwediva). In the case of a grant receiver not handing over the financial aid to the child's caregiver, the ministry could transfer the money to the caregiver of the child, the grant could be stopped, or legal action was taken against the grant receiver (interview: Mr. Nuuyoma, 2012, Ongwediva).

Caregiver-child conflicts due to orphans grants

The usage of the orphan grant for household costs, instead of for expenses of the orphan alone, sometimes led to conflicts between orphans and caregivers. In these conflicts, issues of power play a role. Children often lack social power, as was argued in the introduction to this thesis. Attention therefore needs to be given to the social and cultural constraints in the context in which they operate (Bluebond-Langner & Korbin 2007).

The caregivers navigated in a context of different interests and social rules. The correct usage of the grant by caregivers was not clear-cut: for instance, professionals differed in their description of the expenditure of the grant. Whereas some indicated that the grant should mainly be used for the living and schooling costs of the orphaned child (interview Mr. Nuuyoma, 2012, Ongwediva; Mrs. Kandetu, Deputy director civil registration, 2013, Windhoek), others determined that the grant was also meant for other children in the household and was intended to lift the living standard of the family where the orphan resided (interview Mrs. Shikongo, 2013, Windhoek). The school principal noted that in practice, due to unemployment, many people in the household relied on cash transfers such as the child grant and the old-age pension:

> Our people receive this 200 Namibian Dollar (N$) for the orphan but if they are fifteen people in the house, this money would be used to feed these people. That's why you also see people complaining that the old-age pension is little, it is not little but there might be many people in the household who are not working and each and everyone wants to get a share from this money.

In some cases, such a usage caused conflicts between caregivers and orphans. For instance, Taiwo's aunt took care of her sister's children (the double orphans Taiwo and his sister Tuli) after their former caregiver, their grandmother, had died. She noted:

> Orphans boast of the orphan grant they get. Sometimes I have no support from elsewhere and I take money from the grant they get just to buy something for the house. They would be angry, they are very proud of this grant.

The aunt noted that Tuli had often demanded for her grant when their grandmother was still alive, even forcing her grandmother to collect the grant when she was seriously ill. According to the aunt, Tuli had contributed to her grandmother's death with her behaviour. Due to the recurrent conflicts between the aunt and Tuli, Tuli left the house to stay with another caregiver, and when Tuli passed by during an interview with the aunt, the aunt shouted and scolded at her. Although the aunt clearly played a part in the conflict with her implacable behaviour, her position was difficult: she was a single parent, unemployed, HIV positive, and had to take care of her nephew and niece, missing the support of her late mother.

During interviews, some caregivers likewise stated that orphans were causing problems due to the grants they received because they were of the opinion that 'people want their money'. Both the regional office of the MGECW and the village headman had dealt with caregiver-orphan conflicts over the use of the financial aid given to the orphan. According to the village leader, for older orphans especially the grant sometimes 'got into their minds', and they felt that these adolescents had troubles taking into account the needs of their household. Mr. Nuuyoma (interview 2012, Ongwediva) noted: 'Some of the grandmothers who come here, say they don't want the grant anymore. Because some of these adolescents even want to kill their granny because of that N$200. Or the adolescents say: 'If you don't give me the N$200, I will kill myself or not go to school anymore''. Responses from the MGECW consisted of informing the police to intimidate the orphaned adolescents, or referring these adolescents to social workers for counselling. Thus, the discussion on orphans' economic security makes it clear that financial issues cannot be studied independently from the network of social relations in which they appear. This network of social relations is further discussed in the next chapter.

Children's strategies to restore economic security

The strategies orphans in my study used to improve their economic security included asking for financial assistance to access family support or focusing on their education to compensate for the lack of such support from their parents (see Van der Brug, 2012). Earlier in this chapter, I described that child orphans often found it difficult to ask for financial or material help from their caregivers. Some adolescents in this study however actively asked for financial support from different family members. A few were successful in receiving such support, while the requests of others were refused. For instance, Petrina, a double orphan who stayed with her grandmother often turned to her elder brother for support, but stated that he mostly 'doesn't want to give' when she asked for clothes, money or other needs.

Others said they focused on their education. Most of the adolescents wished for a job in the future and so become financially independent. During interviews, several adolescents noted that when their parents had died, but also in case parents were not working, that it was essential to 'take education seriously' (Foibe), or that orphans have to 'learn to work for themselves' (Alex). Alex explained this by stating:

> The parents that were supposed to help you, they are not there anymore, so you have to study hard, get a job and help yourself.

5.3 DISCUSSION

This chapter shows that a number of the orphaned child and adolescent participants expressed grief and parental loss in primarily financial and material terms; they felt that with the death of their parent they had lost financial and material assistance which their parent could have provided. Economic insecurity due to parental death is thus an essential aspect of their grieving experience. These findings offer support for other grief studies conducted in sub-Saharan African settings among adults (Rosenblatt et al., 2007; Nordanger, 2007) and adolescents (Thurman et al, 2018). Thus, as Van der Heijden et al. (2010) conclude as well, referring to disadvantaged orphans in South Africa: children's manifestations of parental loss or grievances are influenced by their social and environmental contexts (p. 45).

I have contended that the relationship between childhood grief (as an emotional complex) and economic security is inherent to growing up in poverty. The loss of a parent clearly has, in situations of poverty, a greater economic impact on the lives of children than in high-income countries, where more safety nets exist to soothe the financial impact of parental loss. Therefore, Thurman et al. (2018) state that linkages to economic safety nets services could be essential in preventing complicated grief, and help identify those in need of additional support (p. 84). Furthermore, economic consequences may be the most apparent aspect of parental loss for children when the parent has hardly been present in their lives. For instance, the parents of some child participants in my research had died when they were very young. In other cases, the parent was hardly involved in the life of the child prior to their death, as the child stayed with a relative like a grandmother or an aunt from a young age. Lacking food, clothes or money for education are, for children, clear consequences of parental death in such situations.

This study found that the financial and material support that children missed from their late parent for some concerned basic necessities, while for others this had to do with relatively luxury articles and financial support to help them achieve more in life. Sociological perspectives on grief whereby grief is seen as a social emotion and an interpersonal process (Charmaz & Milligan, 2006, p. 525) are useful frameworks to understand this diverse emphasis on economic insecurity within the grief experiences of orphans in northern Namibia. In these frameworks, grief is seen to emerge from relationships, attachments, expectations and obligations (*ibid*.). The findings show that notions such as the issue of meaning of the person or the person's death for the survivor (Klass, 1999), the lost relationship with the deceased (Lofland, 1985), and shattered dreams – such as the loss of what might have been and the abandonment of plans for a particular future (Bowman, 1999, p. 181) reflect ways in which children experience the death of their parents and its financial effect on their lives. These various responses to parental death also show, as Jakoby (2012, p. 705) notes, that grief is a complex, multi-dimensional emotion.

A part of this study examined the economic consequences of parental loss on the lives of children and adolescents, to better understand the ways economic insecurity impacts childhood grief. The findings show that about half of the child orphans experienced their economic situation as worse than that of non-orphans,

while the other half perceived their situation as similar or better. However, the adolescent orphans do not fit this trend as the majority of them perceived their economic situation as worse than that of non-orphaned adolescents. The situation of poor non-orphans, for example children who are 'dropped' by their parents at their caregivers without contributing to the costs of their care, received little attention in the findings section. During the study, however, it turned out that their position is often vulnerable. This mixed image of orphans' economic insecurities is in line with an inconsistent picture found in the literature on differences in economic insecurities of orphans and non-orphans living in contexts of poverty and the HIV/AIDS epidemic. Thus, orphanhood and economic adversity do not have a one-to-one relation and national policies similarly shifted in focus from addressing childhood vulnerability as a result of AIDS-affected to poverty-affected (UNICEF, 2013, p. 52). Furthermore, the findings of this study offer support for considering the introducing a form of child grants of which both orphaned and non-orphaned children benefit (amongst others Meintjes et al., 2003, UNICEF, n.d.a).

This study also examined how *the state* contributed to the economic security of the orphaned participants. This contribution appeared to be diverse. The most important policy to tackle poverty among orphans, the child welfare grant, was found to have a positive effect on the lives of the participants. These findings support Levine et al (2011) who conclude that Namibian cash transfers have poverty reducing effects. However, about *half* of the orphaned participants did not (fully) benefit from the grant even though they qualified for it. Many orphans did not have the required forms or identification which are necessary when applying for the child grant. Furthermore, the child grant was abused by third parties. Thus, a range of reasons contributed to the fact that orphans had limited access to this form of economic support, such as fosterage contexts, adult-child power relations, perceiving an orphan as an asset due to the orphan grant, rules of inheritance, possible economic stressors of remaining parents, and practical issues such as lost documents. My study shows that government institutions took various measures to ensure that orphans benefited from the child grant to a greater extent. However, such measures can be improved, as is discussed in Chapter 7.

Finally, within this study, a distinction was made between economic security, addressed in this chapter, and social security, which is the focus of the

next chapter. However, in several instances these categories are interrelated. For instance, this chapter showed that orphans sometimes experienced social insecurities, such as being teased for their poor appearance as a result of their lack of financial assistance. Thus, their weak economic position made them socially vulnerable. Moreover, the usage of the orphan grant sometimes caused conflicts between orphans and their caregivers when the grant was used for general household costs instead of for an orphan's own expenses alone. In the same line, reduced financial security of foster families triggered intra-household discrimination. Similarly, an orphans' inability to contribute financially to their living costs in the foster household was also a cause for social insecurities in the home situation, such as not being treated well. The next chapter focuses on these social insecurities, and how they are part of children's grief experiences.

6

Childhood grief and child maltreatment

6.1 INTRODUCTION

This chapter addresses childhood grief in relation to the social insecurity of children, especially the treatment of orphans in their households. The majority of Namibian orphans are cared for within their extended families (United Nations Children's Fund [UNICEF], 2011). In these home situations, children's social security can become threatened. A review of qualitative literature exploring the experiences of orphans living in extended families in sub-Saharan Africa (SSA) suggests that these children and adolescents are vulnerable to several forms of maltreatment (Morantz et al., 2013). Furthermore, the lack of a father in the home due to death (or due to absence) places girls in within SSA at a heightened risk for childhood sexual abuse (Kidman & Palermo, 2016). Organisations such as UNICEF have raised concerns about the vulnerability of orphans to maltreatment as well. In their 'Framework for protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS' they stated: 'Impoverished and sometimes without parents to educate and protect them, orphans and vulnerable children face increased risk of abuse and HIV infection' (UNICEF, 2004, p. 9).

A safe and supportive home situation for children seems to be important in adjusting to parental death (Tremblay and Isreal, 1998; Howell et al., 2016). As Himebauch, Arnold and May (2008) note: 'the provision of a safe physical and emotional environment and availability of one significant adult appear to be the two most important predictive factors of a child's successful outcome after suffering a loss' (p. 242). A study in Southern Africa highlighted the negative effects of maltreatment on the wellbeing of parentally bereaved children (Macedo, Sherr, Tomlinson, Skeen and Roberts, 2018). In this study, bereaved children who were exposed to domestic violence and harsh physical punishment were found to show less mental health resilience, thus being less capable in coping with negative life events (*ibid*).

Maltreatment of children in their homes does not only occur among orphans. Many children in Namibia, both orphans and non-orphans, experience the consequences of unstable households. For instance, UNICEF (2013, p. xvi)

notes that a large proportion of Namibian children are the victims of violence perpetrated by a caregiver. In focus group discussions conducted by the National Planning Commission (NPC) in different parts of Namibia, primary school children reported varying levels of verbal and physical abuse in the family, and spoke of child labour (NPC, 2010, p. 42, 45). Child abuse not only receives attention in Namibia, but, as Badoe (2017) notes, child abuse in the whole of Africa 'has become increasingly topical with a dramatic increase in the recognition and an appreciation of the long term harmful effects on the affected population' (p. S32).

Exposure to maltreatment can lead to multiple negative outcomes for children. Nemeroff (2016) describes that in the past two decades much evidence has demonstrated that child abuse and neglect is associated with an increased risk of major psychiatric disorders and medical disorders. For instance, adverse childhood experiences as child abuse may cause depression in adulthood (Danese et al., 2009). Brown et al. (2009) found in a study amongst African children, including those from Namibia, that childhood exposure to physical and sexual abuse is associated with measures of mental health, suicidal ideation, substance use, multiple sex partners and a history of sexually transmitted infections. Additionally, child abuse can predict HIV risk behaviours (Cluver, Orkin, Boyes, Gardner & Meinck, 2011), impaired cognition and academic functioning (Mills et al., 2011).

This chapter discusses children's grief and their responses to bereavement after the death of their parent in northern Namibia in relation to insecurities in their home situation. The first question explored in this chapter is: (i) How does maltreatment in the child's home affect their experiences of loss and grief? Various governmental agencies deal with child maltreatment. The second question relates to: (ii) How does the protection of orphans (for example by the state) influence the social security of orphans? Where in the previous chapter we looked at the relationship between childhood grief and economic insecurity, this chapter focuses on grief and social insecurity. The basic principle of human security is again the starting point. In the following sections, literature relating to the subsequent themes is analysed: the effects of the quality of child care on children's adaptation to parental loss; prevalence and risk factors of child maltreatment in southern Africa; and the treatment of orphans in their households within SSA. We also briefly address discussions on child abuse and punishment. Afterwards, the

empirical data on maltreatment of orphaned children and adolescents in this study, such as the impact of these insecurities on their grief experiences, and support and strategies to restore these social insecurities, are discussed. Korbin (1987) argues that, in order to understand child maltreatment cross-culturally, one should get an enhanced understanding of the conditions under which child maltreatment is more or less likely to occur, such as factors that promote or prevent such mistreatment. The findings section therefore discusses risk factors for insecure home situations in northern Namibia as well.

6.1.1 Children's adaptation to parental loss and the quality of child care

After the death of a parent, a safe and supportive home environment for children appears to be an important protective factor in the way children respond to this loss (Howell et al. 2016; Tremblay et al., 1998). This theme received attention within studies that examined the effects of parental loss on the psychological functioning of bereaved children (*ibid.*). In general, parental death does not appear to significantly increase the risk for psychiatric problems on a clinical level, even though it makes a number of children vulnerable for maladaptive outcomes, as a study conducted in the United States shows (Kaplow, Saunders, Angold and Costello, 2010). Increasingly, research suggests that the quality of child care is an important factor in the way children respond to parental loss (Tremblay et al., 1998; Howell et al, 2016). For instance, based on a review of US studies on children's short, medium and long-term psychological adaption to parental loss, Tremblay et al. (1998) suggests that the quality of parent-child relations and child care both before and after death, the stability of the family situation and the access to social support for both children and surviving parents act as crucial determinants of adaption to parental loss. They conclude: 'Parental death, then is best understood as creating a vulnerability, rather than inflicting a crippling injury by itself: children appear to be at risk for concurrent and later difficulties *primarily to the extent* that they suffer a higher probability of inadequate parental functioning or other environmental support, before, as well as after, the loss of a parent' (p. 431). In a Swedish study on parental death during childhood and depression in young adults, Berg, Rostila and Hjern (2016) similarly argue that in

the case of parental death, 'loss of security, stability and predictability of family routines may give rise to several emotional, social and behavioural problems that can continue to influence psychological health throughout the life course' (p. 1096).

As has been mentioned in the introduction of this chapter, the importance of a supportive and stable home situation is also demonstrated in a study conducted among parentally bereaved young children in South Africa and Malawi (Macedo et al., 2018). This study found that factors such as positive caregiving and a lower exposure to domestic violence, physical punishment or stigma acted as predictors of mental health resilience (*ibid.*). Thus, child exposure to domestic violence and harsh physical punishment were negatively associated with resilience, which demonstrate the harmful impact of maltreatment (*ibid.*). In contrast, positive caregiving such as praise was associated with greater likelihood of resilience (*ibid.*). Other factors that predicted resilience included being a quick learner, aiding ill family members and higher community support (*ibid.*). Another study in South Africa among parentally bereaved children (Collishaw, Gardner, Aber and Cluver, 2015) similarly found that 'better caregiving quality' was one of the five predictors of sustained resilience – resilience was operationalized as consistent positive mental health at 2 time points. Other predictors of sustained resilience included better physical health, food security, better relationships with peers, and reduced violence (*ibid.*). The authors thus note that 'mental health resilience is associated with multiple processes across child, family and community levels of influence' (p. 1).

The construct of attachment is often used to understand the caregiver-child factors which function as predictors of children's psychological well-being when they have experienced adverse events such as parental death (Howell et al., 2016). This theory assumes that a biological need for love and caregiving that is essential for survival forms the attachment between children and parents (Bowlby, 1982). Howell et al (2016) note that within attachment theory, threats to the attachment system can be viewed as highly distressing events for children, and the death of a parent can be seen as a lasting physical separation from the attachment figure (p. 153). Attachment related caregiver-child factors that may predict children's well-being include 'how children express emotions to their caregivers (i.e., expressive coping), how children and parents communicate with each other about parental loss [..] and children's perceptions of 'positive

parenting' behaviours (i.e., parent's reinforcement of children's positive behaviour)' (p. 153-154). In their own study among children who experienced either parental death or cancer, which was conducted in the US, Howell et al. (2016) found that for the bereaved youth, positive parental reinforcement and supportive communication with the surviving caregiver were inversely associated with post-traumatic stress disorder (PTSD). Thus, as the authors note, these two factors 'are potent protective markers of children's positive adjustment, possibly by facilitating a sense of routine and consistency and strengthening children's relationship with the surviving caregiver' (p. 161).

Bifulco, Harris and Brown (1992) note as well that the construct of attachment is important in understanding the effects of maternal loss on children: 'With adequate care prior to and after the loss, the risk of adult caseness is not apparently raised by loss of the mother; therefore, the results suggest that it is the quality of attachment and not the trauma of the loss that holds the key to later psychological well-being' (p. 446). A study on the psychological wellbeing of orphans and vulnerable children impacted by HIV/AIDS in southern Africa similarly used the construct of attachment to examine protective factors (Barenbaum and Smith, 2016). Barenbaum et al. (2016) argue that 'attachment to caregivers is critical in helping these children through the bereavement process and life transitions' (p. 97). The study found that the factors of being connected to a trusted adult and sharing feelings with caregivers when one is not happy were found to be important aspects in establishing a positive well-being in orphaned and vulnerable children (p. 92).

The above mentioned studies thus suggest that children generally deal best with parental loss if they have a safe and supportive home situation, when they are connected to a trusted adult, and when they are able to share their feelings with remaining parents or other caregivers. This last theme, communication patterns between parentally bereaved children and their caregivers, has been discussed in Chapter 4. It is clear that a home situation, in which children experience social dangers such as mistreatment makes it more difficult for children to adjust well to parental loss. In the following sections we will discuss the prevalence and causes of child maltreatment in southern Africa, with special attention on the treatment of orphans in their households.

6.1.2 Child maltreatment in southern Africa: prevalence and risk factors

Despite a scarcity of literature on child maltreatment in sub-Saharan Africa (Morantz et al., 2013), there are indications that child maltreatment rates are high in southern Africa. In South Africa, high prevalence rates of physical and emotional abuse have been observed (Madu, 2003). Richter et al. (2014) found high levels of sexual and physical abuse amongst both men and women who reported histories of childhood abuse from representative communities in South Africa, Zimbabwe and Tanzania. Meinck, Cluver, Boyes and Mhlongo (2015) state that studies within Africa in general consistently report high rates of child abuse, with 'prevalence as high as 64%' (p. 81).

In Namibia, rates of child maltreatment appear to be high as well. According to UNICEF (2016), 'Namibia is grappling with endemic levels of violence against children and women' (p. 1), which includes violence against children taking place within their families, homes, schools, communities and online. Domestic violence is common in Namibia (NPC, 2010, p. 43). In a study on violence in southern African countries, 70% of 1,100 Namibian men and 73% of 1,400 Namibian women said that violence against women was a problem in their community (Andersson, Ho-Foster, Mitchell, Scheepers & Goldstein, 2007). Furthermore, over one in four children under the age of 12 are forced into sexual intercourse (Ministry of Health and Social Services [MoHSS], 2008). The aid agency Lifeline/Childline operates a counselling service for children and young people in Namibia. Data from 2006 showed that, aside from suicidal thoughts, child abuse was the most common reason for seeking assistance (Lifeline/Childline Namibia, 2007).

Belsky (1980) made use of Bronfenbrenner's (1979) Ecological Model of Human Development to further the understanding of child maltreatment. He argued that child maltreatment can be seen as a social-psychological phenomenon that is determined by forces at work in the individual (ontogenic development; such as childhood histories of abusive parents), the family (the micro-system), larger social units like the community (the exosystem) and the wider cultural fabric (the macrosystem) in which the individual, the family and the community are interwoven. Child abuse may be prevented or initiated by an accumulation of risk and protective factors within and across these systems (Belsky, 1980).

Systematic reviews and studies on child maltreatment in sub-Saharan Africa suggest various risk factors for child abuse within these different systems (Morantz et al., 2013; Meinck et al, 2015; Meinck, Cluver, Boyes and Ndhlovu, 2015a). Meinck et al. (2015) found in their review of 23 quantitative studies on physical and sexual abuse in different countries in Africa various correlates of abuse. These included *child-level factors* (younger age, disability, physical health, behaviour and gender); *caregiver-level factors* (caregiver illness in particular AIDS, caregiver mental health problems, caregiver changes, family functioning, parenting, caregiver-child relationship, and substance abuse), *household-level factors* (poverty, household violence, and non-nuclear family), and *community-level factors* (exposure to bullying, sexual violence, and rural/urban location) (p. 81). Meinck et al (2015a) found in their study on physical and emotional abuse victimization in South Africa, using self-report questionnaires, next to the earlier mentioned risk factors poverty and bullying, also the risk factors AIDS-related stigma, school non-attendance and achievement, sexual abuse, caregiver disability, inconsistent discipline, family conflict and living with a step-parent. Morantz et al. (2013) similarly found in their review of qualitative studies the perceived risk factors poverty, living with a non-biological caregiver, stigma, and alcohol abuse by caregivers (Morantz et al, 2013, p. 5-6).

Other studies have looked into the pathways which lead from these risk factors into child abuse. For instance, Meinck, Cluver and Boyes (2015b) found, based on a cohort study in South Africa, that children in families affected by AIDS-illness are at higher risk of physical and emotional child abuse victimization. This risk was mediated by higher levels of poverty in these households and disability (*ibid.*). The authors therefore argue that social grants and parenting interventions are potential ways to positively impact the risk of child maltreatment in South Africa (p. 11). Meinck et al (2017) also looked into how such pathways of child maltreatment may lead to health outcomes in Southern African adolescents. Based on a quantitative study, Meinck et al (2017) found that family disadvantage (caregiver AIDS illness and poverty) was associated with increased abusive parenting, and abusive parenting was in turn associated with higher adolescent health risks (mental health, physical health and problem behavior). They note: 'caregiver AIDS illness and poverty appear to be driving caregiver mental health distress and abusive parenting' which negatively affects adolescent health (p. 61). Thus, child maltreatment rates appear to be high

in southern Africa, and such maltreatment is associated with a variety of risk factors, of which family disadvantage is an important one.

6.1.3 Discipline or child abuse?

The line between discipline and child abuse, especially physical abuse might not always be clear. Montgomery (2009) notes that 'the growth of interest in children's rights has inevitably meant that discussions of discipline are now tied to considerations of abuse. From an anthropological perspective, this has made analyzing the physical punishment of children problematic' (p. 172). Montgomery also states that some scholars' stance is that of cultural relativity. For instance, Scheper-Hughes (1987) argues that within the field of childhood studies, there is a tendency 'to consider the nature of parenting in traditional and non-western societies in the light of the child abuse and child survival preoccupations of our times' and fail to reflect on indigenous theories of socialization and accepted methods of discipline (p. 7). In contrast, other scholars argue 'that emphasizing local ethno-theories of punishment prevents anthropologists from seeing anything they do not want, including the abusive treatment of children' (Montgomery, 2009, p. 172).

Montgomery draws on Korbin's (1981) framework arguing that in order to distinguish between child abuse and discipline, three practices need to be disentangled: 1) cultural practices such as initiations or beatings which may seem harsh, unnecessary or even abusive to outsiders, but which are deemed culturally necessary and have the full approval of the community, 2) idiosyncratic or individual maltreatment of a child carried out against cultural norms, and 3) social or structural abuse of children where children as a group are targeted or when they suffer distinctive consequences as a result of poverty, ill-health or social neglect (Montgomery, 2009, p. 173-174). Montgomery (2009) concludes: 'Abuse is not a single or unchanging phenomenon, and the forms and understanding of it depend on social context, but all societies acknowledge and recognise that some ways of treating children are abusive and cause serious harm' (p. 180).

Quinn (2005) analysed the function of beatings in child-rearing practices. She notes that beating, along with frightening, teasing, shaming and praising are techniques for emotional arousal (p. 481). Quinn argues that emotional arousal is

one of the four universal features of child rearing, which together explain how children are turned into culturally valued adults. Cultural models for child rearing are designed to make the child's experience of those important lessons constant, to connect those lessons to emotional arousal, link them to evaluations of the child as approval or disapproval, and to prime the child to be emotionally predisposed to learn them (p. 507). She presents an example of a case of the Mfante community in Ghana, where a predisposition of fearfulness is founded on the threat of physical punishment (p. 503). Quinn describes that 'the idea that children must first learn to 'fear something' (*suro adze*) in order to make them teachable is the proffered rationale for beating them' (*ibid*). If children don't learn to fear something, such as the stick which is used for beatings, they cannot be trained to have the good character that the Mfantse value in adults (p. 503). Such considerations should be taken into account when studying child maltreatment in a southern African setting.

6.1.4 Treatment of orphans in their households in SSA

Child maltreatment amongst orphans in their households

Various studies have reported experiences of maltreatment amongst orphans within their household in sub-Saharan Africa (SSA): orphans were found to be vulnerable to economic exploitation(Harms et al., 2010), physical and sexual abuse (Birdthistle et al., 2011;Cluver et al., 2011), property-grabbing (Deininger, Garcia & Subbarao, 2003) and intra-household discrimination such as orphans being more likely to go to bed hungry than non-orphans within the same household (Makame, Ani& Grantham-McGregor, 2002), or less likely to be enrolled in school (Case, Paxson & Ableidinger, 2004). As has been mentioned in the introduction, a review of qualitative literature on child abuse and neglect found that orphaned youths living in extended families in sub-Saharan Africa (Lesotho, Malawi, Zimbabwe, South Africa, Uganda, Tanzania, Kenya and Botswana) experienced similar forms of maltreatment (Morantz et al., 2013). The orphans reported experiences of intra-household discrimination; material and educational neglect; excessive child labour and other exploitation by family members and psychological, sexual and physical abuse (*ibid.*). Some of the orphaned adolescent participants of my study, who participated as children in my 2003-2004 study,

experienced intra-household discrimination, verbal abuse and talked about violence being used against children (Van der Brug, 2007). In another Namibian study, orphaned participants reported to have experienced sexual and physical abuse, and to be 'treated as 'slaves' in their home situation (Mushaandja & Ashton, 2013, p. 32).

Although the abovementioned studies give an insight into orphans' experiences of maltreatment, there is no consistent picture of the occurrence of such maltreatment in relation to abuse amongst non-orphans. For instance, Morantz et al. (2013) note that many studies in their review did not provide information on whether orphans are subjected to higher rates of maltreatment than non-orphans. A systematic review of quantitative literature on orphans' experiences of physical and/or sexual abuse compared to non-orphans in four sub-Saharan African countries (Zimbabwe, South Africa, Kenya and Uganda) found that orphans were not more likely to experience these types of abuse (Nichols et al., 2014). The authors however warn that these findings should be interpreted with caution due to the inconsistent quality of the data, and the likelihood of underreporting of abuse by participants also has to be taken into account (*ibid.*). They further argue that a clearer understanding of abuse amongst children and youths within the region is needed (*ibid.*).

Child fosterage and the treatment of children in households

Some scholars argue that contexts of child fosterage should be addressed in order to understand the treatment of orphaned children in their households. Madhavan (2004) notes that one should examine the socioeconomic and cultural contexts of fosterage, kinship, and networks to gain insights into the circumstances of children orphaned due to AIDS (p. 1443). Child fosterage is common in sub-Saharan Africa; as Brown (2011) writes: 'Childcare across sub-Saharan Africa is often socially distributed amongst adults, with care by the biological mother being one of several options available for children. Children typically move within and outside of large extended kin networks' (p. 155). A distinction can be made between voluntary and crisis-led fostering; voluntary fostering includes arrangements which are made between biological and foster parents which are in accordance with cultural norms about child rearing whereas crisis-led fostering

relates to fostering done in response to death or economic hardship (Madhavan, 2004, p. 1444).

Studies on fosterage within sub-Saharan Africa report variations in the wellbeing of fostered children. Brown (2009) found that no differences existed between Ovambo orphans in Namibia who are fostered and non-orphans in the development markers education or health, when utilising the Namibian Demographic and Health survey. Hereby data were collected from a sample of 6678 households throughout Namibia (*ibid.*). In contrast, Scelza and Silk (2014) in their study on the Himba in Namibia note that 'fosterage does appear to impose some costs on children' (p. 462); children are more likely to be stunted and underweight than children living in their biological households. Also Bledsoe, Ewbank and Isiugo-Abanthe (1988) found that young foster children in Sierra Leone are more often malnourished and less apt to receive hospital treatment, and on the whole, foster children are at higher risks of morbidity and mortality. In their study on schooling outcomes in relation to orphanhood and fostering, Hampshire et al. (2015) argue that it is important to take the historical and social context into account. Based on quantitative and qualitative data from sixteen field-sites in Ghana and Malawi, they, for example, see that in 'Malawi, which has been particularly badly affected by AIDS, orphans were less likely to be enrolled in and attending school than other children (p. 141). By contrast, in Ghana, with its long tradition of 'kinship fostering', orphans were not significantly educationally disadvantaged; instead, non-orphaned, purposively fostered children had lower school enrolment and attendance than their peers (*ibid*.)

Various factors within the fostering context might influence the treatment of fostered children in their households. Firstly, whether the fostering is seen as voluntary or as out of crisis can make a difference in their treatment. For instance, Brown (2011) notes that amongst the Ovambo, crisis fosterage does not have the same advantages to the recipient family as voluntary fosterage and children often do not have advocates or adults to hold the recipient family accountable (p. 170). Also Notermans (2008) points to the importance of advocates for the child's wellbeing in their fostered homes. Notermans found in her study on child fosterage in East Cameroon that it is important for the wellbeing of the fostered child to have the biological mother keep an eye on the child by sending messengers with gifts and food, even though foster parents take full responsibility for raising the child (p. 362-363). In contrast, Madhavan (2004) notes that the

fostering of children orphaned in the context of the AIDS epidemic might not be seen as crisis fosterage by the caregivers (p. 1450). Secondly, the relationship between foster parents and the deceased biological parents should be explored (Madhavan, 2004). Thirdly, the degree of relatedness of the fostered child to the head of household appears important (Brown, 2009). Brown (2009) observed that amongst the Ovambo, fosterage may protect orphans who are closely related to their caregivers. In my previous study on life worlds of orphans in northern Namibia (Van der Brug, 2007), I similarly observed that a close relation to the foster caregivers appears important in a good treatment of orphans, especially close kin relations within the matrilineal system (p. 69). According to Madhavan (2004), two other factors might influence the variation in treatment as well: the movement of resources between biological and foster families - the fairness of such a distribution might influence the attitude towards fostered children - and AIDS itself as a possible determinant of fostered children being treated differently from biological children (p. 1450).

6.2 RESEARCH FINDINGS

The findings explore the relation between childhood grief and the lack of a safe home environment. It shows that orphans express their grief over parental loss as the loss of protection against poor treatment *in the household*. Children's experiences of maltreatment in Namibia are not well documented. This section focuses on various forms of mistreatment experienced by orphans within households, and on risk factors that contribute to such abuse. The risk factors show, just as in the previous chapter, that economic insecurity often interrelates with social insecurity. Child protection increasingly receives attention in Namibia. The findings describe responses from the state to protect children, and strategies of orphans themselves to leave an unsafe home situation.

6.2.1 Missing protection of parents

For at least half of the orphans, their responses to parental loss were related to the way they are treated in their homes. Orphaned children said they had to think about their late parent when they were not treated well at home; this included

maltreatment in a foster household, but also situations of harsh disciplining by a remaining parent. 'Thinking about' a deceased parent was perceived by the participants as painful, negative and emotional, and could be considered as part of the grieving experience, as has been described in Chapter 3. For instance, Claudia, a single orphaned girl, who stayed as a child in the household of her aunt where she was maltreated for several years, noted that orphans would relate bad treatment in their household to the loss of their parents. She remarked:

> It might cause children to think about the late parent, and when they are mistreated they would think that is because they are orphans and those who are not orphans, they are treated well.

Non-orphaned adolescents, who lived in household where orphans were taken in, also linked sadness over parental loss to an unfair treatment in the household. They stressed the importance for orphans not to be thinking about their parents, for instance by withholding information about the parent. Aina, a non-orphaned adolescent, stated that information about their parents should only be given to orphans from the age of 15 onwards. By then they would be able to understand that 'even if they were to be treated unfairly, they would not think that is because the mother is dead'. Caregivers also referred to the interrelation between children's responses to bereavement and the treatment of orphans. For instance, a grandmother noted an orphaned child in the household should be treated well, so it would not think about the late parent.

The children and adolescents missed the protection from their late parent. Others felt they would not have been fostered, and thus not be in an abusive situation in the first place, if their parent(s) had been alive. Understanding the meaning of the deceased in the life of the bereaved is central to the understanding of grief (Jakoby, 2012, p. 686; Klass, 1999). In the previous chapter, the significance and role of the parent as *provider* has been described. In the current chapter, the deceased parent was meaningful to children as a *protector* against maltreatment and inequalities in their lives. Both these roles relate to existential securities of children. Diversity in the significance of the deceased in the life of bereaved is also demonstrated in other studies, wherein interviewees mentioned not only the loss of the physical presence of the deceased but also loss of guidance, roots, practical support, reference points in life etc. (Valentine, 2008; Cochran & Claspell, 1987 in Jacoby, 2012, p. 687).

In my study, several children mentioned that their deceased parent could have protected them against bad treatment when he or she were alive, such as in cases when food was withheld. For instance, Hango wrote: 'If my father was alive, I would tell him that I do not eat, he would protect me and I would eat'. This could also be the case when the child was beaten. Liezel, a shy girl whose father had remarried after the death of her mother, was mistreated by her stepmother. Liezel explained she often had to think about her mother when her stepmother was angry, as her mother could have helped her. In a letter to her deceased mother she wrote:

> I want to tell you that I am being oppressed. If you were alive, mum, you would help me. At home I am suffering so bad, I am given a lot of work to do. If you were alive, you would do many good things for me.

Erastus noted that when his father was alive he would not be beaten, as he imagined himself staying under his father's protection. A double orphan who was eventually taken out of his household by a social worker and placed in an SOS children's village (see Chapter 2), also felt that when his parents had been alive, they would have saved him from the harm he experienced in the household of his distant relatives. The boy was reminded of his parents when doing the hard work of the house, and said: 'If they were not dead, I would feel peace. Now people at home shout at me'. In the letter he wrote to his deceased mother, he stated: 'Mother, I am being beaten. Come and protect me! I am beaten and shouted at'.

Other orphaned children, who stayed with their remaining parent, stated that during times when they were punished by their remaining parent, they thought of their deceased parent. Helena thought about her late father when her mother punished her. She noted: 'My father used to defend me'. Martin fantasised that his late father could have comforted him when he was beaten.

Adolescents, who had been staying with an abusive caregiver in the past, remembered that as a child they often thought about their late parents. For instance, Claudia recalled that during the time she was mistreated, she always thought that if she had been staying with her parents she would not have experienced this. The adolescent orphans Hilma, Grace and Petrina, who stayed with elderly caregivers, expressed that they longed for their parents when adults in the house used 'bad language' against them or when they were treated badly. They felt they would not have been in such a situation when their parents had been alive. Petrina commented:

> When I am treated badly, I would start to think about them. I would think that, if mum and dad were alive, I could not be treated the way I am treated now.

6.2.2 Social insecurities in the home situation: child maltreatment

The social insecurities that the orphaned participants experienced within their households are in line with categories of child maltreatment in sub-Sahara Africa (SSA), as defined by Morantz et al. (2013), including intra-household discrimination, neglect, child labour, exploitation and abuse. All of the orphaned child participants, except for one, and two-thirds of the adolescent participants experienced or had experienced some form of maltreatment in their current home situation, or in a former post-loss home situation (see Table 6-1a and Table 6-1b). Hereby it should be noted that the severity of 'beaten' was not clear in all instances. Thus, whether 'beaten' is to be categorised as physical discipline or physical abuse is up for debate (see the section 'Abuse'). The main caregiver was often responsible for an insecure home situation, but also other adults in the household could be accountable such as resident relatives or a housekeeper. Professionals working with children in the region wherein the research area was situated, such as fieldworkers of NGO's and social workers, also indicated that maltreatment of orphans occurred in the region. They mentioned a high workload, no time to do homework, not receiving three meals a day, being physically beaten and verbal abuse. Some of the caregivers who took part in the study similarly had heard about or had observed the maltreatment of orphans in nearby households.

Intra-household discrimination

Several orphans in this study experienced an unequal treatment between themselves and the biological children of the household head or the non-orphaned children fostered in the household. Such *intra-household discrimination* is described by Morantz et al. (2013) as children being treated less well than other children, usually the biological children of the caregiver. For instance by having reduced access to food, clothing and schooling, or having to do excess chores or paid work (p. 3).

Table 6-1a: Categories of maltreatment, experienced by child orphans

Child orphans					
Name	**Discrimination**	**Neglect**	**Child labour**	**Exploitation**	**Abuse**
Taiwo	-	-	-	-	Beaten, shouted at
Festus	No lunch box while others do	-	-	-	Beaten, spending night outside, clothes taken
Boy	Not given food because not liked	No assistance with HIV adherence	Herding cattle	-	Beaten, told to go back to old house, shouted at
Liezel	-	-	Many household chores	-	Beaten
Erastus	-	-	-	-	Beaten
Hango	Not given food, while others get some	-	-	-	Spending night outside
Helena	-	Prevented from attending school	-	-	Beaten
Helvi	-	-	-	-	Beaten
Marthe	Less food in lunchbox, sent to a worse school	-	-	-	-
Martin	-	-	-	-	-

Table 6-1b: Categories of maltreatment, experienced by adolescent orphans

Adolescent orphans					
Name	**Discrimination**	**Neglect**	**Child labour**	**Exploitation**	**Abuse**
Petrina	-	-	-	-	'Bad language'
Nelao	-	No soap, dirty appearance	-	-	Beaten, 'ask your parents for food'
Grace	-	Denied food	Woken up very early to work	Grand-mother tried to acquire house	Beaten, shouted at
Brigita	-	-	-		'You are doing nothing, just like your father'
Meke	-	-	Pounding large amounts of millet, woken up at midnight to work	-	-
Claudia	-	Left alone in house, hut without lock	Pounding large amounts of millet	Father's ID withheld	Beaten, 'told to go to grave for school fees', clothes taken
Foibe	No schooluniform and barefoot to school; herding cattle in rain while others are inside	-	-	-	-
Hilma	-	-	-	-	Beaten, shouted at

In this study, children named issues such as unequal food distribution, a higher workload, and differences in clothing, themes which are depicted in Figure 6-1 - Figure 6-5. Kagumbo who stayed with distantly related family members described in his drawing (Figure 6-1) that one of his caregivers does not give him anything, such as food, when he asks for it because she does not like him. Festus said about his drawing (Figure 6-2): 'It is me without a lunch box. My cousin in Grade 2 who stays in the same house comes with a lunch box. Grandmother buys her food'. Foibe, an orphaned adolescent, made a drawing about her higher workload than non-orphans in the house (Figure 6-3). The drawing shows that as a child she had to herd the animals when it was raining, while the biological children of the house owner, her uncle, stayed inside. Her cousins would also receive new clothes, while she and other orphans in the house would not. All orphaned and non-orphaned participants in this study had heard about unequal food distribution and a higher workload for orphans within households; this theme is depicted in Figure 6-4 which shows an orphaned child without a plate while the non-orphans have one. During group interviews, children also told each other anecdotes about the unequal treatment of orphans. For instance, one boy shared a story about an old woman who would spray water on the roof of their house, telling the orphans they should go to sleep because it was raining which was, however, a trick so that the non-orphans did not have to share their food.

Although the ideal of equal treatment of fostered, orphaned and biological children is stressed amongst the Ovambo, it is not always achieved (Brown, 2011, p. 167). In the same way, the caregivers in this study expressed that they treated all children in their household similar. Nevertheless, they knew about unequal treatment in other households; such as that only new clothes being bought for the caregiver's own children but not for the orphans. A grandmother explained about the unequal distribution of household chores in some houses: 'It happens that the orphan is fetching water, cooking etc. while the other children are sitting. The child will be carrying 25kg of water'.

Figure 6-1: 'My cousin is eating, while I am not eating' (Kagumbo)

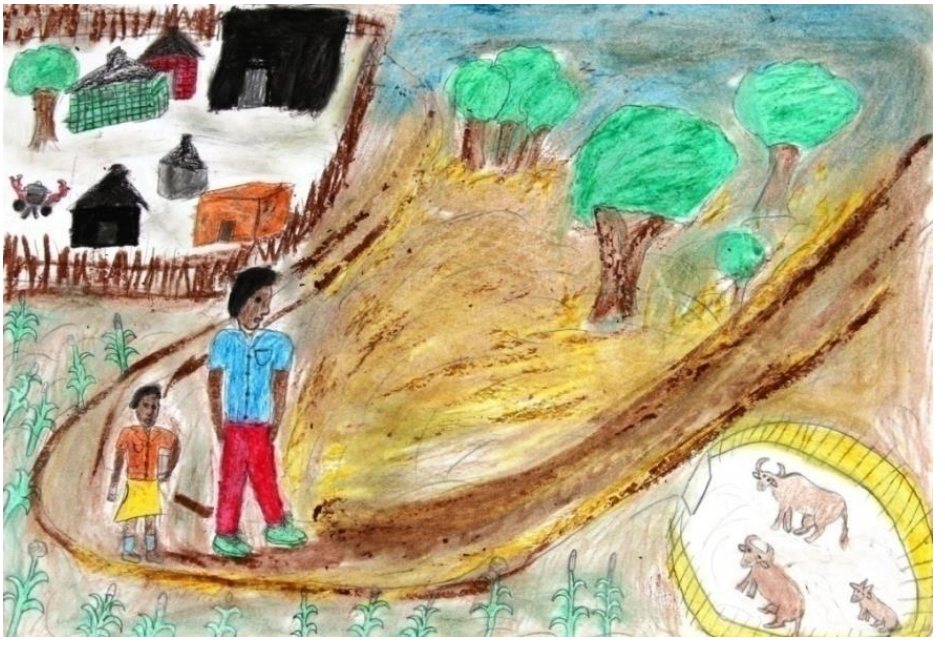

Figure 6-2: 'Only my cousin goes to school with a lunch box' (Festus)

Figure 6-3: 'I used to herd animals in the rain, while the others are inside' (Foibe)

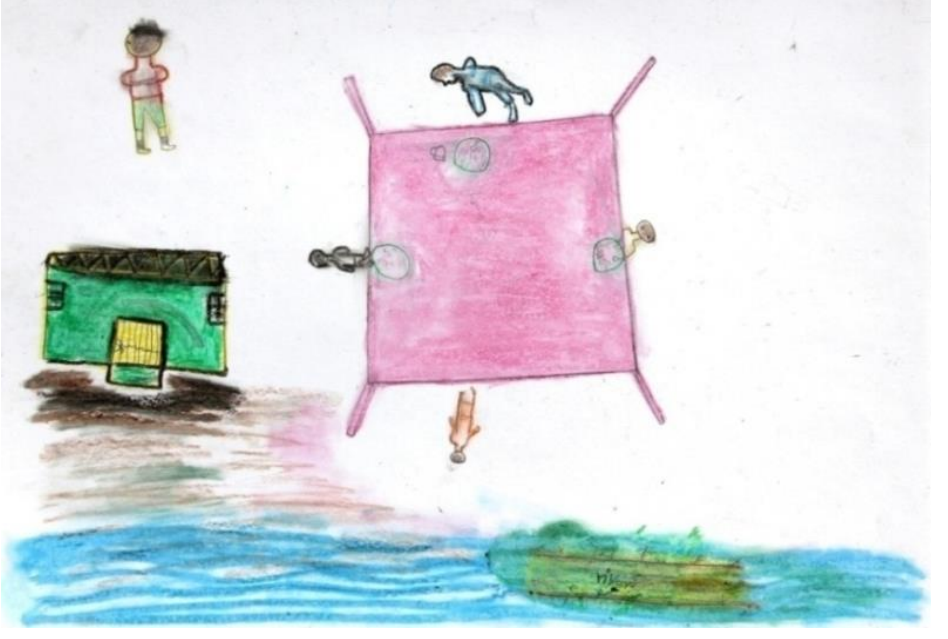

Figure 6-4: 'Orphans are not eating, while others are eating' (Erastus)

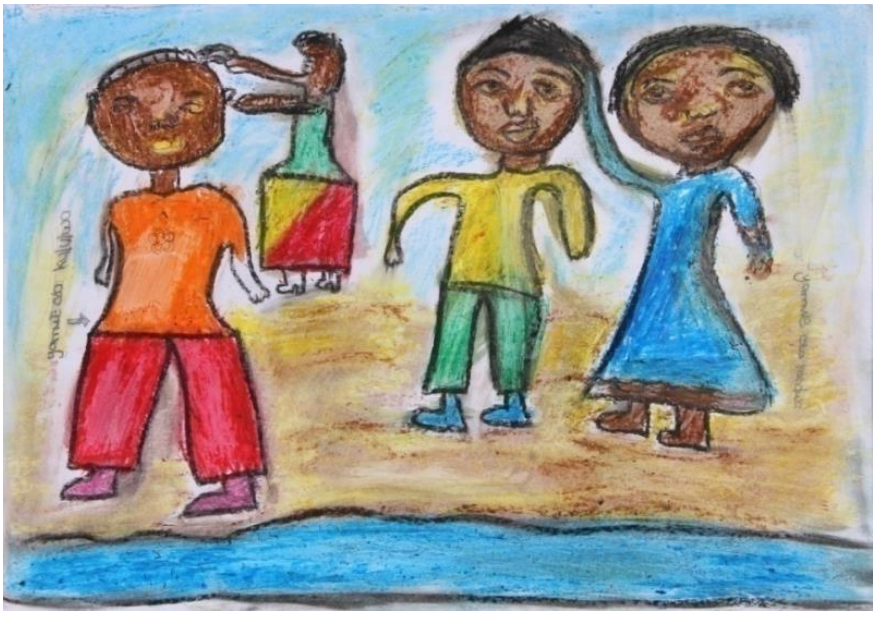

Figure 6-5: 'The hair of my cousin is plaited, but mine is cut short' (Martha)

The following case of the single orphaned child Martha shows that although some caregivers presumed that a different treatment was not noticed by orphans in their household, the orphans themselves were well aware of these differences. Martha's caregiver, her aunt, indicated she treated all children in her household equally, even though her own children were attending good schools in town and the non-biological children in the household attended the local village school. She felt this difference was not apparent to the non-biological children, as she would tell them they would have similar (but unlikely) opportunities. She stated:

> Like my son now goes to school in town, the other one is at boarding school and the other one again is schooling in another town. Now we cannot tell Martha and the others that my children are at boarding schools because their father pays for them, no. We convinced them that they should study hard, so that they can as well go to those schools when the others are done there.

To Martha, this unequal treatment in the house was clear, as she explained:

> Our cousin who goes to school in town is treated differently from us – my other cousin and me. The other cousin is not an orphan, both her parents are alive but they are not the children of the owner of the house. My cousin's hair is not cut but always plaited (see Figure 6-5). At home there is enough food but we do not have enough food in our lunch boxes.

> The one who goes to school in town always has juice while we do not and if we have three slices of bread each, she would have six slices of bread. Sometimes my birthday gets celebrated but they do not buy me things. They only go in the field picking beans and maize, and cooking them. They say it is nice that I was born that time of the year when there are beans and maize in the field.

Neglect

A few orphans mentioned cases of neglect in their foster households. Child neglect refers to 'the failure of those duty-bearers to provide the basic necessities of life for the child's development or to ensure the necessary standards of care and protection of the child' (UNICEF, 2013, p. 105). Morantz et al. (2013) distinguish between *material neglect*, such as hunger and ragged clothes, *overt neglect* such as leaving young orphans home alone and *school neglect* such as reduced schooling due to a lack of finances to pay for school fees or uniforms. Fieldworkers of NGOs, who were working with orphaned children, similarly noticed material neglect amongst orphans: orphans were not given food even though there was no food scarcity in the household, and orphans did not receive love from their guardians. Other professionals noted that school neglect was uncommon, and when it occurred it was often reported by neighbours or other community members to the authorities.

Orphans in this study experienced material and overt neglect. The caregivers of a HIV positive double orphan did not assist him with HIV drugs adherence nor accompany him to the clinic, as a result of which he had a poor health. Foibe, an adolescent orphan who was fostered from a young age by her aunt, experienced neglect as a child: she went to school barefoot and did not have a school uniform, while the other children in the house did. During the 2003 study, when Claudia stayed with an aunt as a child, she was left alone in the house for long periods of time, and had to sleep in a hut alone without a lock. This frightened her, and she started to suffer from bed-wetting. Grace, a double orphaned adolescent who was taken care of by her grandmother stated she was sometimes denied food as her grandmother accused her of not contributing to the households costs:

> Some days I don't eat. There is food but my grandmother has bad manners. She says that when my father was working he never helped and it is my father that brought the disease [HIV] to the house. I become

> angry when she says I must not eat because I am not the one who brings food in.

Helena, an orphaned single child, stayed after the death of her father with relatives, were she was neglected:

> I got beaten and denied to eat. If I went to work in the field in the morning, I had to continue to work there, and would be denied to go to school. I used to think about my father, taking his photos, looking at them and I would start to cry, and then I would get beaten when they saw me crying. I was very dirty because I was not taken care of. Later I went to my grandmother, and she was treating me well. I never thought I would be alive, I will never forget what they did to me until I die.

Neglect may also lead to other forms of social insecurity. As a child, the double orphan Nelao was not well taken care of by her grandmother she was staying with, who differentiated between the non-orphans and orphans in the household. She had no soap to wash herself, and when she received clothes, her grandmother would take them away and give them to other children in the house. Nelao described how her teachers punished her for her dirty appearance:

> Even teachers were saying I am dirty, I must wash myself. But I think maybe they did not know the situation. They were always beating me so that I would wash myself but I did not have soap to wash myself. [...] Like the day I cannot forget is the day that a teacher was beating me, she said I must sit on her chair and she beat me. [...] The teachers would always make a comparison between me and other kids whom we were staying with. I and Solomon [another orphan in the household] were looking different from them, because I can remember Solomon's school uniform was torn, but grandmother said there was no money for him to buy a new school uniform.

Child labour

Morantz et al. (2013) describes *child labour* as excessive domestic chores; wage labour; livestock tending; being lent out as domestic workers; taking on tasks due to their old age caregiver's frailty – all demands which exceeds those of other children and interferes with their schooling (p. 4). Although the categorisation of Morantz et al. is adopted in this study, one can be flexible on whether children's contributions to the household income or household survival are regarded as child labour. Evers, Vadeboncoeur and Weber (2015) write: 'the tension between universal children's rights and the need for children to contribute to the survival of the family and community, in fact, are at the core of the debate concerning child

labour' (p. 55). The way childhood is portrayed thus plays a role in views on children's work. Lancy (2008) notes that 'nowhere are Euroamerican views on childhood and those of the larger world more at odds than on the issue of work' (p. 234). The Ministry of Labour and Social Work (MoLSW) estimated that about 8% of all children in Namibia are engaged in work; the majority of these children live in rural areas and are engaged in 'reasonable household chores that are considered as part of children's family responsibilities' (NPC, 2010, p. 44). The 2005 Child Activity Survey found that 80% of the children who participated responded that such activities took up little of their time, whereas 7% felt that their work took up too much of their time (MoLSW, 2008). The home can become a site of labour exploitation when children have to carry out agricultural or household tasks which are unacceptable for them (NPC, 2010).

Some orphans in this study described excessive domestic chores and a high workload in foster homes, such as pounding large amounts of millet (see Figure 6-6), cutting large pieces of wood, tending to live stock for long periods of time and doing a lot of agricultural work. Fieldworkers of NGOs confirmed the high workload of orphans in the region, and stated that sometimes 'orphans are used by people just to do whatever job may come'. As young children, the orphaned adolescents Nelao and Grace were often woken up in the early hours of the morning by their caregivers to start working; as a consequence they had difficulties concentrating at school. Meke, who lived as a child with a sister of her great grandmother who did not treat her well, spoke about her drawing (Figure 6-7): 'It is about a child who is given a lot of omahangu (millet) to pound. This is how many orphaned children are treated at their homes. I know that because I experienced it'.

Figure 6-6: Claudia depicted how she had to pound a lot of millet for her aunt with whom she lived

Figure 6-7: 'Pounding large amounts of millet' (Meke)

Exploitation

Exploitation has been characterised by Morantz et al. (2013) as 'property grabbing' by family members, including the removal of goods from family homes, appropriating land or denying orphans their inheritance (p. 4). An example of property grabbing within this study is mentioned in Chapter 5; Claudia's relatives refused to hand over the ID of her father. Furthermore, Grace's grandmother tried to appropriate the house, which Grace inherited from her parents. After the death of Grace's parents the grandmother had moved in to take care of her grandchildren, but tried to get hold of the house by telling the children to leave.

Abuse

A number of the orphaned children and adolescents indicated they experienced 'insults' and harsh punishments such as beatings within their homes. These experiences are in line with the categories of emotional and physical abuse, as outlined by Morantz et al. (2013).

Emotional abuse amongst orphans within SSA includes being threatened, being made to feel like a burden, or harassment by community members and children at school (Morantz et al., 2013, p. 4). Emotional abuse and neglect are often defined as a carer-child relationship that is characterised by patterns of harmful interactions, but not necessarily requiring physical contact in order to harm the child (Glaser, 2002). The 'insults' experienced by orphans in this study often referred to the children as economic burdens of the household. Furthermore, guardians would refer to the child's parents, the parent's death, and to AIDS as the cause of death in negative ways. Fieldworkers of NGOs similarly mentioned that when children asked for financial support they would, for instance, be told that their parent had 'only given birth to the child, but had not given birth to materials'. In my study, Claudia recalled that when she asked her caregiver, her aunt, for school fees, she was told to go to the grave of her father to collect her school fees there. Brigita noted that, when she would come back from school or when she went to sleep, her caregiver would say 'you are not doing anything here; you are just like your father', even though she carried out numerous household chores such as pounding millet and fetching water. Kagumbo described how his caregivers often made remarks which made him feel bad; he commented:

> They also say bad things. They took us from another district but now they say that my sister and I can leave the house any time we want and go back. But they know we do not have family members there anymore because they all died.

Morantz et al. (2013) listed overt physical abuse under *physical abuse*, which is more severe than the practices of physical discipline that are commonly practiced within much of SSA (p. 5). A general definition of physical abuse includes an act resulting in a non-accidental physical injury, including intentional assault and unreasonable punishment (O'Toole, 2003). In Namibia, corporal punishment continues to be widely accepted (UNICEF, 2013, p. 107). A 2007/08 study carried out in eight Namibian regions asked respondents with children in the age range of 2-14 to report on one child in the household (LAC, 2012, p. 104). This study estimated that about half of all children who participated in the study had been subjected to some form of physical discipline, and about a third had suffered 'excessive physical discipline' in the previous three months (p. 104-105). In my study, the regional Women And Children Police Unit (WACPU) noted that abusive ways of treating children in their homes occurred in the region where the research took place, including beatings, stabbings with machetes, and the burning of children's fingers as a punishment for stealing.

Several child participants, both orphans and non-orphans, mentioned beating as a discipline measure at their homes. During Kids Club exercises, when children were asked what made them unhappy, several indicated they were unhappy when they themselves or other children from the house were beaten. A few children considered beatings to be a necessary discipline measure. For instance, a photo taken by an orphaned child participant during the picture taking assignment (see Chapter 2) shows a grandmother beating a young child, who lies on the ground, with a stick. The child who took the picture noted that the boy in his household had been naughty, and explained: 'It is good because if he was not beaten he would continue insulting people'.

It seemed some orphans experienced more severe beatings. These children expressed they were mostly beaten when they refused to do household tasks such as collecting firewood or water, or when they made a mistake. Fieldworkers of local NGOs also mentioned that a proportion of the orphans taking part in their projects were severely beaten in their foster homes. In this study, a few orphans described how they were beaten by their caregiver.

Grace, an adolescent orphan whose grandmother had often hurt her, for instance with a walking stick and an iron stick, commented:

> When my aunts came, one of them saw that I was angry so she asked why I was angry and I told her that it was because my grandmother had beaten me with her walking stick until it broke. My aunt then gave me 10 Namibian Dollar. Then there was the time that my grandmother told me not to set foot in her kitchen so I used that money to buy bread and powdered oros (lemonade) to survive on for a whole week. I would eat two slices before school, two slices after school and also in the evening. In the past, my grandmother would sneak up on me and beat me, but it does not happen a lot anymore because I would bite her. There was a time when she caught me and hit me with an iron stick on my head but then I managed to bite her shoulder. After the walking stick incident, my aunts warned me to run away from her whenever she wants to beat me so I do that now. She still threatens to beat me but she just screams at me now. She has very small wrists but if she catches you, it will be hard for you to get out of her grip.

Taiwo, a double orphaned child, wrote in a letter to his deceased grandmother, who had taken him in after his parent had died, about the beating by his aunt:

> Grandmother come back home, I am suffering my grandmother! Come back home and help me because I am being beaten a lot at home! Come and buy me food, I am being mistreated!

Kagumbo said that he was regularly beaten by his caregivers with a stick. Claudia remembered that she was often attacked by her aunt, where she stayed as a child. During an interview, she showed the scars of these beatings which were still visible years later. Helvi, a single orphaned child, was taken care of by a 'housekeeper' during times when her mother did seasonal labour in southern Namibia. She described that the housekeeper would beat her regularly, for instance when she refused to do household tasks. The housekeeper threatened her and told her not to tell anybody about the beatings, as Frieda would then be hurt even more. Figure 6-8 and Figure 6-9 show drawings by Liezel, in which she depicts herself being beaten by her stepmother who had accused her of stealing something from the house. Nichols et al (2014) found in their systematic review that orphans living with a stepmother in sub-Saharan Africa are especially vulnerable to discrimination and care deprivation, as they may resent caring for the orphans.

Figure 6-8: 'A child beaten at home' (Liezel)

Figure 6-9: 'A child beaten at home 2' (Liezel)

Some non-orphans experienced physical abuse as well. For instance, Emilia, a non-orphaned adolescent participant described how she was afraid of her father as he had started to mistreat her after he became disabled and unemployed. Emilia fled the house, to stay with a cousin, but her father forced her to come home. She related: 'My father came there with two sticks tied together and he wanted to beat me.' The maltreatment resulted in her having difficulties doing her homework.

A few orphaned children experienced other punishments which they perceived as harsh, such as having to spend the night outside the house. For instance, Festus described how when he came home late from playing, his grandmother would sometimes not open the door to their homestead, so he had to sleep by the stem of a tree. This punishment is also mentioned by children in other regions in northern Namibia (NPC, 2010, p. 43). Fieldworkers of local NGOs had comparable stories of severe punishments, for instance orphans who had to attend school without warm clothes in the winter. Nelao, an adolescent double orphan who was beaten regularly as a child by her grandmother, explained the impact of such treatment:

> At my grandmother's house every time you are just angry, every time you are just crying. If school is out, your heart will not feel good. But when you go to school, you feel better than at the house. When I was at school I could not really concentrate, I would always be thinking about what will happen at home.

Morantz et al (2013) include various factors under the category *sexual abuse*, such as being forced into prostitution, forced to marry young, or young girls forming relationships with older men ('sugar daddies'). Sexual abuse can be defined as a non-consensual act of a sexual performance with a child or youth, including rape, incest, oral copulation, and penetration of the genital or anal opening by a foreign object (O'Toole, 2003). The child and adolescent participants did not bring up any sexual abuse. Possibly, this type of abuse was underreported; rape is the most commonly reported form of violence against children in the age range of 8-20 years in the region, whereby the majority of perpetrators are family members or domestic workers (interview with representative of the regional Women and Children Protection Service [WCPS], 2013). Rape often occurred in rural areas as these regions are isolated, and children belonging to child- or junior-headed households are especially vulnerable for rape as they lack the protection of adults (*ibid.*). However, an NGO staff member noted that rape also often took place in the

region's urban areas as cross generational relationships, such as sugar daddies, were more common in towns.

Abuse might have adverse consequences for children's self-esteem. A psychologist working in the region observed that the abuse of orphans, talking negatively to them, and family members pushing them down, led to a poor self-image amongst orphans.

6.2.3 Risk factors for insecure home situations

Participating caregivers and experts named several risk factors for an orphan's insecure home situation. Based on Belsky's (1980) framework for child maltreatment, Meinck et al (2015) and Meinck et al (2015a) distinguished various categories for risk factors in relation to abuse amongst vulnerable children in South Africa. In this study, caregivers and experts mentioned hazards within three of these categories, namely child-level, caregiver-level and household-level risk factors.

Child-level risk factor

Some caregivers and the village headman mentioned that mistreatment was often 'caused' by orphans' disobedience. The headman noted that mistreated orphans were often 'not following the rules of the house'. While the larger part of the caregivers felt that orphaned children behaved similar to non-orphans, others were of the opinion that orphans generally behaved badly. They felt that although caregivers were often pointed at as the ones maltreating orphans, in reality orphans were the ones misbehaving. Orphans were especially difficult to handle when they had become adolescents; e.g. orphans would then refuse to be sent for things, and they would 'answer them badly'. Some caregivers argued that orphans misbehaved due to the grant they received, as orphans suspected their caregivers were after their money. One caregiver said: 'Those who are bringing up orphans are in trouble'. These perceptions about orphans resemble the factor 'parent perceives child as a problem' which Stith et al (2009) found in their meta-analytic review to be a risk factor for child neglect. Korbin (1987) also argues that certain categories of children appear more vulnerable for maltreatement than others; for instance those who display oppositional behaviour. Some experts provided

explanations for the perceived problematic behaviour of orphans. A social worker observed that orphaned adolescents, in particular, felt unwanted or lacked attention in the home situation, which caused behavioural problems. An NGO staff member explained that the exclusion of orphans from talking about the late parent and secrecy about their parent's cause of death led to orphans being rebellious, which contributed to their maltreatment:

> It is not a lot of caregivers who have the skills to sit with the child and try to explain it at a level that the child will understand. So they will end up mistreating these children because the children are asking for answers about their parents, answers the caregivers cannot give. Caregivers are stuck with the problems and they cannot deal with the loss themselves.

Caregiver-level risk factors

Supporting the findings of Morantz et al (2013) and Cluver et al (2016), participants and experts identified alcohol abuse by caregivers as an additional contributor to maltreatment. One of the orphaned adolescents, Meke, stayed with her great aunt as a child, during the 2003 study, who was often drunk. Meke recalled she had been frequently left alone in the house at night because her great aunt went to the *cuca shops* (local bar) or her drunken great aunt would wake her up at midnight and force Meke to cook for her.

Experts identified HIV infection of the caregiver as a risk factor as well. An officer at the Ministry of Gender observed that aunts who received Antiretroviral Therapy (ART) were a group of guardians where mistreatment occurred frequently. In my study, Taiwo, a child orphan, was not treated well by his caregiver, an HIV positive aunt; he indicated he was beaten frequently and did not receive enough food. Although the aunt only referred indirectly to her HIV positive status during interviews, and did not talk about the effects of her illness on her life, she explained about the stress she experienced being a single parent and foster parent with only little means to support the children. She also complained about the difficulties of taking care of Taiwo's HIV positive adolescent sister, who was rebellious, and not taking her HIV medication. Such cumulative stresses might form a basis for mistreatment.

Some caregivers further stated that sometimes children were mistreated because of the character of their caregiver: 'Some people are just bad by nature', 'Some people are just heartless', and 'Some people don't like other people's

children'. Caregivers also mentioned that in some cases, orphans were purely taken in as a labour force, for instance to cultivate millet or herd cattle. Other caregivers mentioned that sometimes orphans were only taken in because of the child grant. Regional officers from the MGECW similarly observed this. For instance, a caregiver noted:

> The other thing I noticed as well is that, when people see that the orphan receives the grant, they take the child so that they can be the one to receive the money for the child. That's why sometimes when you look at orphan children you would see they are neglected, the child does not have shoes, proper clothes, or school uniform, the child is dirty, and the hair is not cut.

Experts also mentioned that the type of relationship that existed between the foster caregiver and the late biological parents influences the treatment a child receives. Bledsoe (1990) suggests that in Sierra Leone this relationship has more impact on the treatment a child receives than kinship links themselves. In the same line, a traditional healer in my study noted that when children of fellow clan members were fostered, previous conflicts between the caregiver and the biological parent of the child could result in maltreatment of the child. The traditional healer explained:

> In a clan, when something would happen to someone - like hardship- but other clan members did not support that person, that person will feel revenge. When one of the clan members dies, then that person will mistreat the children of the clan member.

Similar stories were told in interviews. For instance, Martin, one of the child participants, lost his mother due to AIDS during the research, some years after his father had also died as a result of AIDS. Shortly before her death, his mother had strongly advised his older brother, that he and Martin should keep on living in their house without an adult (thus forming a child-headed household), instead of moving to the households of relatives. Their mother feared that the children would be mistreated there, due to conflicts that existed between her and her relatives. According to some experts, children who are taken in by non-kin also run risk to be mistreated as a result of the relationship that existed between their foster caregivers and biological parents. These caregivers used to be friends with their late parents, but 'along the way the caregiver gets tired of the children and the lack of support and starts mistreating them'. Other experts stated that when the fostering of orphans was motivated by shame towards the community if they

would not, this could also lead to maltreatment; as such motivations for fosterage do not have a sustainable basis.

Household-related risk factors

Poverty within households is identified as a risk factor for maltreatment in many studies on child abuse and neglect in South Africa (Cluver et al., 2016; Meinck et al., 2015). In my study, experts and participants provided various examples of how limited economic resources of foster families contributed to the maltreatment of orphans. Experts noted that reduced financial security of a foster family, for instance after a drought, often triggered unequal treatment between the families' biological and foster children, as the needs of the biological children would then be prioritised. Some caregivers observed more intra-household discrimination in situations with high living costs, such as urban foster households, compared to rural households. Furthermore, the lack of planning of sick parents about who would take of the child after their death often led to fostering circumstances with a financially unequipped caregiver. An NGO staff member explained these foster situations:

> You find people just forcing themselves to accept these children who are a burden to them. For example the family is so big, and because it is your sister's child; you want to take in a child you cannot afford. And then comes the financial pressure that you are now going to put on yourself, you are now going to end up not treating these children the way you are supposed to treat them, because you are stressed of the situation you put yourself in.

Caregivers described that orphans' inability to contribute financially to the foster household – if orphans did not receive an orphan grant, nor financial or material support from a remaining biological parent, sibling, or other relatives – was a further cause for maltreatment. In some households, orphans were often reminded about their lack of contribution to the household costs and their own living costs. A caregiver commented:

> In some houses you will find orphan children of whom some get the grant and others do not. So in those cases some caregivers say to the children who do not get the grant: 'You are eating because there is a grant of the other, you – you do not receive any grant'.

This social pressure of 'seeing for yourself' within households is likewise observed by Thomas (2006) in her study amongst AIDS-unwell patients in the Caprivi

region in north-east Namibia, who are taken care of within the households of their relatives (p. 3174). The author argues that the pressure to be self-sufficient or contribute to support networks can result in intra-household tension. Korbin (1987) also argues that children who stress family resources are a category of children that appear more vulnerable than others for child abuse.

Non-orphaned children who do not contribute to the household costs seem to be likewise vulnerable for maltreatment in foster households. The practice of 'dropping' children at the grandparents or other elderly caregivers by young women, without supporting the household financially or staying in contact, was seen by caregivers as a problematic development of 'modern times'. They noted that if these parents would not 'bring anything home' the child would be at risk for not being treated well. Madhavan (2004, p. 1446) notes that most non-crisis fosterage arrangements in Africa involved, in theory, a sharing of costs by biological and foster parents. However, when biological parents could not fulfil their obligations, for instance during the apartheid time in South Africa, an enormous financial burden was placed on foster parents (Madhavan, 2004, p. 1446). As is suggested here, such financial burdens may in some cases lead to mistreatment. Thus, social insecurities of orphans within the home situation often interrelate with financial factors.

6.2.4 Support and strategies to restore social security

Studies on child abuse within SSA recommend a multidimensional approach in responding to child abuse (Bowman and Brundige, 2014; Badoe, 2017). Such an approach should involve state and non-state actors, different professionals, the community at large, and it should include a focus on prevention (Bowman et al., 2014). Community capacity is especially important in dealing with child abuse in Africa, as the family and community function as crucial base unites of child protection (Badoe, 2017, p. S34). Badoe (2017) recommends child protection bodies that can encourage open discussion of violence against children and can identify services and persons (in schools, institutions, villages and police stations) to whom children can safely and confidentially report and talk with (*ibid.*). Bowman et al. (2014) argue as well that, when it comes to child sex abuse in the family, 'services of all sorts - preventive, medical, police, therapy, and the like - must be

accessible locally and must involve the local community, including its leaders' (p. 290). Based on their findings that show an early onset of child sexual violence in sub-Saharan African countries, Kidman et al (2016) advise that programs should be adapted for younger age groups. The responses to child abuse in northern Namibia and challenges in providing a sufficient system of child protection are discussed below.

Responses to child mistreatment

Different organisations and parties in my research area addressed the social security of children in their home situations, including the WACPU, social workers, the regional counsellor and the village leader. In the villages, representatives of some of these organisations were active, such as the Women and Men network, a voluntary police network, and community child care workers. School staff would mostly report (school) neglect, misuse of grants, physical abuse and rape directly to the WACPU and to officials of the MGECW. Neighbours and relatives often reported to the local representatives, regional counsellor and village headman. The village headman sometimes applied penalties, for instance, when the mistreatment would continue despite a warning, in these instances the perpetrator might be punished by paying a fine.

However, these involved parties face some challenges in providing a sufficient system for child protection. A study by the NPC (2010) showed that the status and operations of the WACPU needed more attention. Alongside this, there is a severe shortage of social workers and community child care workers (MGECW, 2010; UNICEF, 2013, p. 50; interview: Deputy Director of Child Care Services of the MGECW in 2013, Windhoek). In the research area, only a few social workers were responsible for services to a large area (interview: Social Worker, 2012, Oshakati). They felt overburdened and were mainly occupied with investigations relating to foster care and maintenance grants, leaving little time for child-protection issues (*ibid*.).

Furthermore, community members and relatives were reluctant to report child mistreatment. For example, the Deputy Counsellor noted that the beating of children was rarely reported, generally only when 'it has gone to the extent that everybody can see what is going on', and rape cases were usually only reported when the rape occurred on a regular basis. This was caused by a lack of

confidentiality in dealing with reports of child mistreatment amongst the police and social workers, and a low visibility of community child workers (interview: Deputy Director of Child Care Services, 2013). Besides, caregivers observed that reporting child mistreatment in a neighbouring house 'would disturb the peace between you and the neighbour.' The head of the Social Welfare Grant Allowance similarly explained that neighbours usually did not report abuse as it would affect relationships between neighbours:

> In our culture we like hiding things. Maybe you know that the child is being physically abused but you cannot come out. Some neighbours are free and come to report anonymously, but often they don't want to break the neighbourhood, because if it is known that you reported your neighbour, tomorrow you will not be on good term with the neighbour.

UNICEF (2013) also notes that violence against children in Namibia is underreported, possibly due to various reasons, such as: 'persistent beliefs that such acts of violence, when committed against a child, are acceptable forms of parental authority or 'discipline', the notion that children are 'property', gender inequalities in child-rearing practices, and high rates of acceptance of corporal punishment' (p. 107).

Children and adolescents are expected to report mistreatment to teachers, school counsellors or to the child helpline of Lifeline/Childline. However, they seldom did so. The Deputy Counsellor stated that children almost never reported to the counsellor themselves. Teachers mentioned that their learners did not inform them about their problems at home. The village leader alone noted that children would sometimes report abuse to him. According to the Deputy Director of the Child Care Services, rural children did not often report as they are 'not open, less informed and don't know where they should go to'. In the case of rape by a relative, the Deputy Counsellor noted that elders in the family often intimidated the child to not speak up about it, and explained that adults generally expected that a child would forget about the abuse. According to a WACPU representative, children generally did not inform their parents about a rape incident, but would go instead to the Women and Men network or school counsellors. She commented:

> Parents and kids do not really have this relationship that the child can talk about these issues, maybe that is why the child does not report to the parent. Sometimes the parent does not want to believe it is truly *tate*

> (father, other male relatives, or sir) who did this to you, no, he does not do that.

Lifeline/Childline described that in the rural areas particularly, children who reported via the helpline were difficult to help as they were hard to locate: their houses were difficult to find, and children frequently used other people's mobile phones or changed sim cards regularly.

Child protection is increasingly a focal point in Namibia. In 2015, Namibia adopted the 'Child Care and Protection Act' which provides a legislative framework to protect the rights of children, conforming to international agreements on children's rights (UNICEF, 2015). Various child protection measures are key topics within this act such as a children's ombudsman, children's courts, parenting plans, guidelines against corporal punishment, measures to prevent child trafficking, procedures and rules for foster care and adoption, appropriate support services and shelters (MGECW, LAC & UNICEF, n.d.). For more severe forms of child labour, the domestic law reform was adopted in 2009 that prohibited human trafficking (UNICEF, 2013, p. 112). Other focal points to improve the security of children include the incorporation of the protection of women and children in the national police training curriculum; school safety programmes; and a database on case reporting (UNICEF, 2016). Furthermore, the importance of prevention measures in Namibia is generally emphasized, such as behaviour changes amongst young people in relation to seeing violence against women and children as acceptable, and educating on children's rights in schools.

Children's strategies to leave insecure home situations

Children who live in homes where they are maltreated seem to be in a position with little possibilities to exercise their agency. However, orphans in this study used different strategies to leave their insecure home situation (see Van der Brug, 2012). Thus, as Hockey and James (1993) argue in a general sense, children are both part of a world with social-cultural structures which are determined by adults, and at the same time social actors with some agency within these worlds.

A number of orphans ran away from the foster household where they were mistreated. Running away is not socially acceptable for children as the community often holds the child responsible for the way they are treated. Taiwo moved to his paternal grandmother's house which was situated in the same

village. His elder sister had already run away to this household after several conflicts with their caregiver. Taiwo did, however, not open up on whether he had run away, or whether someone had come to take him. Earlier during the research, Taiwo had already explained that children can move to another household when they are mistreated, on their own initiative or through adult intervention. Brown (2011) similarly noted that Ovambo children sometimes negotiate living arrangements themselves, although this is generally incongruent with cultural rules of fosterage (p. 169). Parsons (2010) states as well that it is clear that children and young people in southern Africa who have lived amongst various households, have had some influence on where they should live. In my study, Meke also ran away at the age of 12 from her great aunt's household to her grandmother's house. However, her relatives did not blame her for running away, as they knew about the great aunt's problematic behaviour. Meke commented that her great aunt tried to take her back:

> I went back to my grandmother's house but my great aunt came and fetched me. But later on I decided to go back again to my grandmother, it was the same story, she even came to get me back again, but then I decided to not go back with her that time.

In 2010, the double orphans Grace, her brother and cousin ran away from their home, where they stayed with their abusive grandmother, to a church acquaintance who had been a friend of their late mother. According to the acquaintance, the children were underfed when they arrived. She explained that first Grace's brother had sought shelter at her place and later on Grace and her cousin as well:

> The first person who came here was Grace's brother, the boy happened to be chased away from the house by the grandmother and he had to spend the whole night in the open before he came to tell me the story. I called the brother of Grace's mother, and he also did not know what is wrong with his mother. Then the other children also spent the whole night outside the house, and came here as well. From that I said: you can stay with me.

Running away does not always lead to a stable situation. After some months, Grace decided to move back to her grandmother, although the children were treated well and could focus on their homework as they did not have to do household chores. This decision was partly due to the pressure from her family who complained that the grandmother could not stay in the house without

Grace's help, and partly because of remarks from school friends that she was not taken care of by her own family. Before the children returned, the acquaintance requested a social worker to talk with the grandmother. During an interview after her return, Grace stated that although the beatings had stopped, her grandmother still used 'bad language'. In 2011, the grandmother physically abused the children again, where after the neighbours warned the regional counsellor, who forced the grandmother to leave the house. In 2011, Grace had become head of the household and responsible for growing food and the care of her sibling and cousin.

Another way for children to leave an insecure home situation was by informing a related adult or older sibling about the mistreatment. For instance, Nelao turned to her older sister at the age of 13. She described that her sister took her out of the house and arranged that she could stay with an aunt:

> I told my sister I was not treated well. And then, one day, she went to my grandmother's house and slept there, maybe for a week, and she found out it was true. She took me out of the house.

Emilia, a non-orphaned adolescent, was abused by her father after he became unemployed. Her sister suggested to her to endure the situation until she had finished school. After she had failed the school year twice, her sister arranged for her to move in with an aunt to be away from her father, and at the same time live in the proximity of an educational institution for out-of-school youths.

There are limitations to a child's possibilities for leaving abusive home situations. In a practical sense, children are only able to run away when there is a nearby (related) household that can take them in. Informing a relative only has an effect when the relative *can* be contacted, and when they decide to act. For example, Claudia, an orphaned adolescent, had never informed her mother about the mistreatment by her aunt, as she was always around when her mother came to visit. Only after her mother saw her wounds during a holiday at home did she keep Claudia home. Thus, as can be expected, children seem to restore their social security mostly within their network of relatives, instead of turning to state aid. These strategies give insights into structures that could be strengthened or developed on a community level to prevent child abuse; these are discussed in Chapter 7.

6.3 DISCUSSION

The loss of protection is an important element of the orphan's grief experiences in this study. Orphans felt the parent could have protected them from unequal or maltreatment in their foster household, or they would not have been in a vulnerable situation in the first place if the parent had not died. These responses confirm the importance of looking at the child in his/her social and family system when studying childhood grief (Silverman and Worden, 1993, p. 315). Tremblay et al. (1998) note that 'loss is more usefully conceptualized as an extended and multi-faceted process, whose impact on survivors is strongly influenced by surrounding circumstances and stressors (such as social support), and by how the various roles performed by the deceased are fulfilled, reshaped, or left vacant in his or her absence' (p. 426). In this chapter, the role performed by the deceased parents, as well as the meaning of the deceased to the bereaved as *protector* against maltreatment stands central. Meaning-making of parental loss among these children thus incorporates the loss of a safe home situation. A safe home situation not only has to do with the existential security of children. Various studies also suggest that a secure and safe physical and emotional environment act as a crucial predictive factor of a child's successful outcome after suffering the loss of a parent (Trembley et al, 1998; Himebauch et al, 2008; Howell et al, 2016). Therefore, the quality of child care appears an important factor in the way children respond to parental loss (*ibid*).

Nearly all orphaned child participants, and two-thirds of the orphaned adolescents, spoke of the unequal or bad treatment they experienced in their post-loss home situation. These social insecurities are in line with various categories of child maltreatment in sub-Saharan Africa, as defined by Morantz et al. (2013), namely intra-household discrimination, neglect, child labour, exploitation and abuse (emotional and/or physical). The degree and frequency were *variable*. Beatings were most commonly mentioned, ranging from disciplining to physical abuse whereby sometimes the scars were still visible years later. In some cases, children even fled the house in order to seek a secure home situation. A limitation to this study is that maltreatment was not studied among the non-orphaned participants – although some of the non-orphaned adolescents reported maltreatment in their homes. It is therefore unclear how the extent of maltreatment among orphans related to maltreatment among non-orphans in the

research area. The findings are, however, in line with the picture that is painted by UNICEF and the Namibian government (UNICEF and Republic of Namibia, 2013, p. xvi): in Namibia, the level of violence against children in the domestic setting is problematic.

In this study, various risk factors, based on Belsky's (1980) framework for child maltreatment, were distinguished. These included: *child-level factors* (orphans are perceived to be difficult to handle), *caregiver-level factors* (alcohol abuse; HIV infection of the caregiver; economic benefits to take in orphans; conflicts between the foster caregiver and parents before its death); and *household-level risk factors* (poverty; orphan's lack of contribution to households costs). These categories suggest that contexts of fosterage should be taken into account when looking into child maltreatment among orphans in northern Namibia. For instance, the findings suggest that the relationship that existed between the foster caregiver and the late biological parents influenced the treatment a child received. Furthermore, the distribution of resources between the (nuclear) biological family and the foster family was seen as a cause for maltreatment, for instance when orphans could not contribute financially to the household. This shows again the interplay between economic and social insecurities of orphans, which is discussed in the previous chapter. Such interplay is likewise found in the financial stresses of households as a risk factor for child maltreatment. Furthermore, the findings suggest the influence of bereavement: behavioural problems of orphans, caused by a lack of communication about the deceased parent, or by feeling unwanted in the foster household were perceived as a risk factor for child maltreatment.

Finally, this study examined how state actors contributed to the social security of orphans in northern Namibia. It appeared that various challenges still exist in providing a sufficient system for child protection, especially when it comes to attending the needs of rural children. A shortage of social workers, reluctance within the community to report child maltreatment and a focus within the system on the self-reporting of children, even with low rates of reported maltreatement, are among the challenges. This study further shows that children's own strategies to escape from unsafe home situations include running away to households of other relatives or family friends, or to inform a close relative from outside the household about the abuse. This shows that, as Vermeulen and Greeff (2015) argue, that internal and external family resources should be also be explored in response to child abuse. They note that, for example in South Africa, strengths

within families have to receive attention as legislation and policy frameworks are not sufficient to assist families wherein child abuse occurred (p. 555). In their qualitative study on child sexual abuse they found internal resources such as sibling relationships and the children's ability to cope with the abuse; and external family resources such as the support of extended family members and friends (*ibid*.). Such focal points are one of the steps needed in achieving a multidimensional approach as response to child abuse.

7 Conclusion

7.1 INTRODUCTION

In sub-Saharan Africa, the scale of orphaning is large. Many children in this region have experienced the loss of a parent. Africa is also the most affected region by HIV/AIDS in the world. Childhood grief in African settings has received little attention (Bray, 2003; Foster, 2002), as well as the bereavement experiences of children in HIV endemic settings (Sherr and Mueller, 2009; Van der Heijden and Swartz, 2010). However, as I have claimed, there is a need for understanding children's experiences of bereavement. Such knowledge contributes to our theoretical understanding of childhood grief and to the improvement of bereavement care. There is also a need to contextualise childhood grief as social and cultural contexts may pattern grief experiences. Attention to children's experiences and perceptions is in line with the relatively new field of the anthropology of children and childhood, to which this thesis is a contribution. This field seeks to document children's perspectives on, and participation in, the social world.

This study took place in northern Namibia. This rural area has a large number of orphans, partly due to a previously high AIDS mortality rate (National Statistics Agency [NSA], 2014a; Ministry of Health and Social Services [MoHSS], 2009; UNAIDS, n.d.). It is also a specific cultural setting; nearly all participants belonged to the Ovambo ethnic group. The purpose of my study was to explore the grief experiences of children and adolescents bereaved of one or both parents in northern Namibia, and to examine cultural, social and financial contexts of bereavement in order to provide a more in-depth understanding of childhood grief as a psycho-biological *and* culturally and socially expressed phenomenon.

Four main conclusions van be identified in this thesis. *First,* the Kids Club is an important research method to study sensitive issues such as grief among children. This is especially significant when such research takes place in a context with an unspoken atmosphere surrounding the issues of HIV and death. This method allows for a balance between, on the one hand, encouraging children to express their feelings and on the other hand protect children against a stressful research situation. This method effectively elicits children's perceptions on

bereavement. These perceptions, as this research has shown, do not necessarily match those of adults. *Second,* this thesis showed a difference between the way grief is experienced individually by children and the established cultural rules in dealing with grief. Thus, whereas their experience of grief is clearly influenced by Ovambo cultural notions, at the same time several children feel differently from how these notions prescribe they should cope with loss. These children feel sad for a long time and are not able to forget about their parents although they are told they should. *Third,* relationality, especially intergenerational relations, is an essential aspect of children's grief experiences. Caregivers are reluctant to discuss feelings in relation to parental loss and provide information about the child's deceased parents, although children would like to obtain such information. Among children, there is individual variation: due to the avoidance of sadness several children do not wish to talk about their late parents. Various factors, in part HIV related, form the basis of this limited caregiver-child communication. *Fourth,* this study shows the important role of economic and social security in children's feelings of loss and grief. Many children experience an increase in financial insecurity and unequal or bad treatment in the foster household due to parental loss; these factors can be seen as secondary losses. Such losses refer to the consequences of a loved one's death and may affect the way bereavement is experienced.

These conclusions also come to the fore in the summary of the findings (section 7.2) and in the description of the scientific relevance of this thesis (section 7.3.1). Section 7.2 also addresses how, at different levels, HIV and the fosterage situation of children influence children's bereavement experiences.

7.2 MAIN FINDINGS

Characteristics of childhood grief in northern Namibia

The findings of my study revealed several ways in which Ovambo cultural notions regulated grief in children. The *duration* wherein children and adolescents can express is restricted. They were not allowed to express their grief after the funeral, which takes place within a week after the death. This was due to a few reasons: 1) the adults I interviewed perceived children's grief as an experience that does not last long; 2) crying after the mourning time had ended could cause

illness; or 3) the crying over the loss of their parent could indicate children were not treated well by their new caregivers. Thus, culture polices grief, as Gross (2018) notes: 'all cultures regulate their members' mourning, subtly or openly, implicitly or explicitly' (p. 46). Most children were informed about the death of their parent and had been allowed to attend their funeral. This in contrast to previous customs, when their parents and grandparents were young, where children were shielded from death. However, children were generally still not allowed to attend funerals from other relatives. Keeping children away from death and funerals had been based on the belief that this would protect children from emotional distress, it would help them to forget, and avoid nightmares and fear. It was perhaps related to a fear of harm from death 'pollution' as well. My study also revealed the ways in which the caregivers attempted to handle death and loss. Caregivers urged children to *accept* the death of their parents and to focus on their new lives and new caregivers. They also insisted that orphans should *forget* their parents. This was sometimes actively encouraged by preventing children from looking at pictures of their deceased parents, destroying possessions of the deceased, or by removing a child from its household where it had lived with its parent(s). At the same time, the dead were *remembered* by sharing stories about the deceased, and the mentioning of the work the person had done.

Cultural or social structures may not only impact the *expression* of grief, but also shape the *experience* of it (Hollan, 1995; Hemer, 2010). I argue that Ovambo cultural notions influenced children's expressions and experiences of grief, but did not completely decide it: several children experienced grief differently. In line with Ovambo notions, most children indicated they did not cry openly over the loss of their parents after the funeral. Furthermore, they experienced processes of forgetting and remembering in dealing with loss. For instance, orphans distinguished between two forms in which they looked back at their deceased parent: 1) the negative thinking about what he/she is missing now the parent is no longer there, and 2) positive memories about the parent through looking at pictures, or through talking about the deceased with others. Less 'thinking' about the parents was seen as part of the forgetting process, while 'positive memories' equates to the adult notion of remembering. However, other experiences *deviated* from Ovambo cultural notions. A number of children mentioned that they were sad for a long period of time, or noted that the death of their parent was something they would never forget. Straight (2010) writes about

this discrepancy between individual grief experiences and cultural notions in dealing with death: 'in spite of cultural taboos about public grieving, against handling corpses, against any number of experiences or beliefs associated with death, people weep for their loved ones, cradle their heads, and whisper their names long after being told they should not…' (p. 143). Thus, cultural meaning and social structure relate to the emotional experience of grief, but not completely. Stroebe and Schut (1998) claim that people often balance between two forms of coping with loss, namely loss-orientation and restoration-orientation. Whereas Ovambo caregivers strongly emphasize *restoration,* such as attending to life changes, avoidance of grief and a focus on new relationships, this study shows that for children, loss orientated ways of dealing with grief are important as well.

Interestingly, dreams about their deceased parents were often part of children's and adolescents' responses to bereavement. On the whole, such dreams were perceived as unpleasant and frightening. An important explanation for such dreams was that children were not able to forget their parent as dreams would actually be 'thoughts' about the parents. In other cases, they were perceived as real dreams or they would be related to witchcraft. I make the point that these dreams somewhat interfere with Ovambo notions of dealing with childhood grief, such as the restricted duration of expressing grief. For children, dreams appear to be a way to express their sadness after the permitted duration or it possibly offering them some room to talk about their parent. For instance, children were sometimes comforted after having told about frightening dreams or their caregiver showed them a picture of their parent after having dreamt about him or her. The majority of the children, however, did not talk about their dreams.

Limited caregiver-child communication on parental loss

Personal grief occurs within a social context and is often embedded in a web of relationships, of which those within s family system are probably the most important (Bosticco & Thompson, 2005; Gross, 2018, p. 53). My study focused on family processes following bereavement in northern Namibia, especially caregiver-child communication on parental loss. Such communication was found to be difficult, complicated in nature and had various types of obstacles. Based on my findings, a communication model was developed to provide insight into all of the aspects involved.

Both caregivers and children/adolescents were reluctant to talk about the deceased parent. For the caregivers, it was almost self-evident not to raise the subject. My study revealed that various factors hinder communication by caregivers, including their view that children are too young for such conversations, taboos regarding talking about death, and fear for their own emotional distress as a result of the questions. The findings show that the choice of limited communication was influenced by HIV as well. Often, caregivers could not provide information about the deceased parent as they had not known the parent themselves. For instance, because they were distant related to the orphan in their care, if closely related caregivers had also died of AIDS. Furthermore, most caregivers were silent about the parental cause of death, especially when the parent had died of AIDS. Reasons for not disclosing the deceased parent's HIV infection to the child included: the fear that the child could not keep the diagnosis secret; fear that the child would suffer from associated stigma; the feeling that it was 'hard to tell' the child about the HIV infection; the fear that a HIV positive child would blame the parent for infecting him or her; and concern about the emotional burden of parental HIV disclosure for children.

Among orphans, other factors played a role in not talking about parental loss. It would protect them from becoming sad or worried, and for this reason they were also reluctant to hear information about their parents. Some factors were related to the orphans' fosterage situation. These included children's fear that caregivers would interpret questions about their parents as criticism of the way they treated orphans in their care. Furthermore, children often could not find 'the right time' to ask their remaining parent about their deceased parent when the remaining parent sporadically visited them in their foster families. Besides, children were hurt when their deceased parent was spoken about negatively in the foster family.

Nevertheless, several orphans showed a clear need to talk to their caregiver about the loss suffered. They also wanted clarity about the cause of death of their parents. My findings showed that many older adolescents would be, according to their caregivers, entitled to know the cause of death of their parents, as opposed to younger children. However, they too were not informed about the cause of death, even if they specifically asked for it. Such secrecy surrounding a death, Karpel (1980) argues, can be perceived as a communication practise that withholds information from bereaved individuals who might need it during their

grieving process; it affects relationships and leads to distrust and anxiety. The adolescents, in particular, reported to have such feelings. Orphans also wished to form an image of their late parent by receiving information about them, and some wondered if they could recognize their own behaviour in that of their own parents. Therefore, this study offers support for the viewpoint that the need for information and memory sharing is related to an individual's sense of identity (Neimeyer, 1999), as loss can be viewed as a disruption of the narrative identity (Baddely and Singer, 2010). I thus conclude that there is a clear discrepancy between, on the one hand, an orphans' need to discuss several facets of parental loss with their caregivers and on the other hand, their caregiver's willingness to have that discussion, especially if HIV is the parental cause of death.

The expression of grief in financial and material terms

Orphans not only have to deal with the relational and emotional side of parental loss, but also with the economic side. The death of a parent can threaten a family's or a child's sense of security due to the loss of financial support. My data showed that several orphans expressed grief in financial and material terms. This concerned orphans who experienced an increase in financial insecurity after the death of their parent, for example, if it was no longer self-evident that school fees were paid. It also concerned orphans who had not known the parent – the child was very young at the time of death or due to an absent parent - but for whom financial insecurity was a clear consequence of parental loss. Some adolescents, however, concluded that the parent did not contribute financially before its death, so that their death made no difference. Fosterage patterns among the Ovambo, whereby many children typically move within large extended kin networks (Brown, 2011), and the increase in lover relationships among the Ovambo whereby partners do not live together (Tersbøl, 2002) contribute to the fact that many children in northern Namibia do not live together with their biological parents. I argue that this element most likely plays a role in the extent to which children express parental loss in terms of financial insecurity instead of emphasizing the emotional effects of this loss. This emphasis on the loss of support is probably influenced by differences in household wealth and orphan's development stages. My findings revealed that for some orphans, the support they missed from their late parent concerned basis necessities, while for others this had

to do with relatively luxury articles and financial support to help them achieve more in life.

In Namibia, parental loss may have serious financial effects on the lives of children. Several orphans in this study spoke about a lack of food, clothes and school materials. These children's weak economic position also made them socially vulnerable, such as being teased for their poor appearance. Many children in Namibia, both orphans and non-orphans, experience the consequences of poverty and unstable households. Increasingly, it has been argued that other factors, such as household wealth, are more decisive than orphaning with regard to child vulnerability in sub-Saharan Africa (e.g. Govender, Reardon, Quilan and George, 2014; Akwara et al., 2010). The data of my study showed a similar pattern: whereas half of the child orphans experienced their economic situation as worse than that of non-orphaned peers, the other half perceived it as similar to or better. Nevertheless, HIV adds to a child's vulnerability when parents or caregivers feel unwell or die due to AIDS.

This study also examined how the *state* contributed to the orphans' economic security. The child welfare grant was found to have poverty reducing effects. The grant contributed to the family income and/or was used for school fees and clothes. However, about *half* of the orphaned participants did not (fully) profit from the grant. Many orphans did not have the necessary forms or identity documents to apply for the child grant. Furthermore, the grant did not always reach orphans, as it would leak to third parties - caregivers either used the money for their own expenses or did not stay with the grant's recipient (for instance, the remaining parent) and would not hand over the money. Negative side effects of the child grants included caregiver-child conflicts in cases where the grant was used for general household costs instead of for the orphan's expenses alone.

The loss of protection as part of children's grief experiences

In addition to economic insecurity, several orphans had to deal with social insecurity, such as unequal treatment or abuse within the foster household. I argue that the quality of caregiving is thus an important aspect in understanding the grief experiences of parentally bereaved children in northern Namibia. My data revealed that children longed for their parents if they were treated badly. Orphans felt that the parent could have protected them from unequal treatment or

maltreatment, or they would not have been put in an abusive situation in the first place if the parent had not died. This relationship was also mentioned by Ovambo caregivers who stated that orphans should be treated well, so they would 'not think about' the late parent. Psychological research has, in my study, contributed to a more comprehensive understanding of the way children's grief and the quality of caregiving interrelate. This area of research is often based on attachment-based models of bereavement. Such research (see Chapter 6 for an overview) shows that children can deal best with parental loss when they have a safe and supportive home environment and when they are connected to an adult they trust. In contrast, an abusive home situation makes it more difficult for children to adjust well to parental loss.

Unfortunately, the majority of the orphaned participants experienced social insecurities in their post-loss home situation: nearly *all* children, and *two-thirds* of the adolescents, commented on the unequal or bad treatment they had experienced, of varying degrees and frequencies. These experiences correspond to various categories of child maltreatment in sub-Saharan Africa, as defined by Morantz et al (2013). Beatings were most commonly mentioned, ranging from discipline to physical abuse, and some children even fled the house to seek a secure home situation. I make the point that my data thus offers support for the notion that Namibia has a problematic level of violence against children in the domestic setting (UNICEF and Republic of Namibia, 2013, p. xvi). Household-level risk factors for child maltreatment that are distinguished in this study, such as poverty and orphan's inability to contribute to household costs, show again the interrelation between social and economic insecurities. Additionally, some risk factors are related to Ovambo fosterage patterns, such as that a caregiver would foster a child due to clan relatedness, despite previous conflicts with the deceased biological parent of this child, which in turn can result in child maltreatment. The role of HIV and AIDS also emerged as risk factors, such as the HIV infection of the caregiver. This was also apparent in orphans' experiences of verbal abuse. For instance, caregivers sometimes blamed the deceased parent for bringing HIV into the house. This affected the relationship with the child and resulted in verbal abuse. The orphans being abused generally had few options to defend themselves. Strategies that these children used to get away from abusive home situations were running away and finding shelter with other family members or acquaintances, and informing others about the maltreatment.

7.3 SCIENTIFIC RELEVANCE

The scientific relevance of this research concerns three aspects. First, this study has used a special research methodology, where ethical issues in conducting research with children have been extensively addressed. This method has yielded novel research results which may not have been observed with other research methods. A further added value of this thesis is the use of different approaches towards the study of grief, from combining the disciplines of anthropology, psychology and sociology. The contribution of these approaches to the study of childhood grief in an African setting will be addressed below. Along this, we also focus on the extent to which Ovambo solutions help children deal with grief. I argue that these solutions are valuable, however at the same time, children most likely benefit from open communication in relation to parental loss.

7.3.1 Kids Club as a research method for sensitive issues

In this study a research method was used, the Kids Club method, which I previously developed in research with orphans (Van der Brug, 2007; Van der Brug, 2011), with a focus on discussing sensitive subjects with children who are not used to being asked for their opinion. This method can be applied to other groups of vulnerable children as well. Orphans in Namibia form a vulnerable research group, and a study on childhood grief means that sensitive topics are raised. Moreover, the study took place in a context with a general unspoken atmosphere surrounding the issues of HIV and death. In addition, some orphans experienced maltreatment in their foster homes. For the research process, this necessitates the need for a careful, respectful and empathetic approach in order to avoid research conditions which might be stressful for children. At the same time, children must be encouraged to express their personal feelings in order to understand their grief experiences. Methodologically, a balance must be found to reconcile both of these aspects. Through the use of the Kids Club method, a balance between the two aspects has been achieved, while complying with the ethical guidelines of the Society for Research in Child Development (SRCD). The Kids Club method consisted of bringing children together in a group for a longer period of time. During the meetings, group discussions took place, and various

non-verbal and creative methods were offered such as drawing and painting. Next to the Kids Club, one-to-one interviews were conducted and the children were visited at home. The Kids Club was particularly suitable for younger children; the adolescents in my study preferred individual conversations when discussing difficulties in their lives. However, they also wished to meet as a group in order to "encourage" each other.

The important question as to whether a researcher should trigger emotions in children that are not discussed within their own cultural setting needs to be reflected on. By using the Kids Club method, I aimed to encourage children to express their experiences and feelings in relation to parental death. Whereas among Ovambo caregivers, there is a strong reluctance to speak about parental loss and death with children. In my study, various elements helped to ensure that this contrast would not be problematic for children. *Firstly*, the design of my research was aimed at preventing participant distress. The role of the researcher is important here, for example by reducing power inequality between child participants and the adult researcher, and sensitivity during interviewing requiring appropriate research skills and an awareness to the needs of the respondents. Furthermore, ethical issues such as 'non-harmful procedures', 'ongoing consent' and confidentiality were pivotal in my study. *Secondly*, I worked together with local child and youth care professionals. A social worker provided support during the study, and after the research had ended participants received the social worker's contact details. My interpreter, who was trained as a counselor and resided in the research area, remained in contact with the children and adolescents after the fieldwork period had ended. *Thirdly*, the Kids Club method was evaluated positively by both adolescent and child participants. To gain insight into the (emotional) effects of the method, we received feedback from the adolescents of my study who had previously participated in a Kids Club as children. They remembered what the method entailed seven years later, and had good memories of it. It gave them a chance to talk about the difficulties in their lives, a space where they felt they were being listened to, they also experienced sharing stories as 'encouraging', and for some, participation helped to strengthen their self-confidence. The current children were also positive about participating. Those who had expressed their sadness over their parent's death during interviews said that they had enjoyed participating. Nevertheless, reflection on

triggering emotions remains an important guideline during research with children on sensitive issues in order to use a careful research approach.

I argue that the Kidsclub method has yielded results which other methods most likely would not have elicited. First, this research method has elicited *valuable responses in children*. Previous research on the grief experiences of young African orphans (Daniel, Apila, Bjørgo & Lie, 2007; Howard, Matinhure, McCurdy & Johnson, 2006) noted that children's responses often remained limited, especially among young children. More generally, the qualitative, open approach to researching grief has shed a spotlight on children's grief experiences which are generally not mentioned in quantitative studies on childhood grief. Examples are the emphasis on financial insecurity and maltreatment, thus, highlighting a broad palette of aspects of grief.

Furthermore, repeating the Kids Club method seven years later has provided a *longitudinal approach*, which contributed to the quality of the research findings. For instance, it has given insight into child maltreatment among orphans. Adolescent orphans were open about the abusive home situation they had been in at the time of my previous study (Van der Brug, 2007), but from which they had moved out of during later years. As children, however, they had kept silent about these abusive practices – mostly likely because they depended on their caregiver. Similarily, a few child participants of the current study did not open up about their home situation, while abuse was suspected. The longitudinal approach has also provided insight into the temporality of orphans' depressive complaints. My study showed that the depressive feelings adolescents spoke of mostly occurred during times when they experienced hardship such as being without financial support; however, when their situation improved, these complaints also disappeared. This offers support for Skovdal's warning (2012) against pathologising HIV-affected children in sub-Saharan Africa. He argues that 'a continued focus on the psychological distress experienced by HIV-affected children runs the risk for medicalising their social experiences, which in turn may transform the social landscape in which children give meaning to loss and difficult experiences' (p. 461).

7.3.2 Combining disciplines towards a contextualized perspective

Through the use of theoretical approaches towards grief from the disciplines of psychology, anthropology and sociology, the study of childhood grief has been enriched, as demonstrated in this thesis. Valentine (2006) argues that within the study of bereavement, especially through the use of discursive approaches, a growing cross-disciplinary debate occurs in which disciplines can draw from each other's insights (p. 74). In this section, we too address the question as to what the disciplines can learn from each other, and add to the study of childhood grief.

The main contribution of anthropology is its perspective on the cultural contextualization of the individual process of grief. Anthropological studies demonstrate such contextualization; for instance, Brison (1995) reflected on how individuals draw on cultural beliefs to make sense of suffering after the loss of a loved one. Ethnographic studies also contextualize grief more broadly, such as Nordanger's (2007) study on grief in Tigray, Ethopia, which focused on socioeconomic, religious and socioemotional discursive perspectives of grief. My findings showed various examples of cultural contexts of grief among children, such as restrictions in the duration and expression of grief. In addition, processes of forgetting among adolescents might be an indication of the socialisation process of grief experiences (see Chapter 3). Furthermore, power inequality between adults and children played a role in dealing with parental loss as children were often not allowed to ask questions about their deceased parent (see Chapter 4). Cultural notions of orphanhood also appeared in this study; being perceived as an orphan was not strongly determined by age, instead vulnerability was essential, such as not being able to provide for one's own livings costs. Attention on children's contextualized grief experiences is important; an understanding of children's lived contexts is central to the design of effective interventions (Dawes & Donald, 2005).

Psychology contributes through its broad theorization of bereavement. It appears that within anthropology, the development of theories on the experience or nature of grief has been limited. Anthropological grief studies often reflect on the usability of psychological theories (Leavitt, 1995; Hemer, 2010) or draw from a more general study of emotions. In contrast - although the discipline is more known for a 'medicalized' perspective of grief - psychologists often seem to have laid the foundations of theories that emphasize attention on the social (and to a

lesser extent, cultural) context of grief. For instance, attention on meaning-making and the sharing of memories (Neimeyer, Burke, Mackay & Van Dyke Stringer, 2010); the concept of continuing bonds (Klass, Silverman & Nickman, 1996); a focus on different ways of coping with grief, which is influenced by cultural norms (Stroebe et al., 1998); and cross-cultural psychological research on grief (Rosenblatt, 2001). In my study, such theories and concepts were, amongst others, useful to understand children's ways of coping with grief.

Sociology contributes to the understanding of childhood grief through an emphasis on perceiving grief as a social phenomenon. Such perspectives on grief, including those whereby grief is influenced by relationships, expectations and future-orientations appeared to act as useful frameworks in gaining insight into orphan's loss experiences in his study. For instance, attention on notions such as the meaning or the role of the deceased parents for the child (in this study: the parent as provider or protector), helped in assessing the children's focus on the loss of financial and material support and protection against maltreatment. The concept of 'shattered dreams'; the loss of what might have been and the abandonment of plans for a particular future (Bowman, 1999, p. 181) was useful in understanding their emphasis on the loss of opportunities and relatively luxurious support. Furthermore, attention for sense-making of death within sociology may provide insights into the resilience of bereaved children.

Thus, the combination of disciplines contributes to our understanding of childhood grief, and to the social, cultural and financial contexts that may influence this experience. It provides space to interpret children's responses to parental loss in northern Namibia; such a perspective is therefore useful in an approach based on the anthropology of childhood. Valentine (2006) argues that the social context of grief is increasingly addressed in grief studies from the disciplines of anthropology, psychology and sociology, as well as an acknowledgement that grief may be experienced differently among individuals and in different settings. She notes: 'the twentieth century's last decade has witnessed a fuller engagement with the differentiated experiences of the bereaved by all three disciplines to restore grief's sociality' (p. 73). Demmer (2007) argues, based on his study on bereavement in the context of HIV in South Africa, that a 'more holistic understanding of bereavement' is needed to understand grief experiences in such a setting (p. 837). He states that an 'ecological' perspective of bereavement is needed, thus the recognition that bereavement may be shaped by

social, political, cultural and economic factors (*ibid*.). My study showed that this is a useful term for understanding children's contextualized experiences of grief in an African setting.

7.3.3 Ovambo solutions towards dealing with grief among children

The pattern of dealing with death among the Ovambo leaves children and adolescents little room to express and share their grief. It also gives children few options to talk about, or get information about, their deceased parents. This raises the question as to whether this way of dealing with loss is beneficial for children and adolescents.

What is the value of local customs like the emphasis on forgetting? Hutchinson (2007, 2011) stresses the function of *recovery*; she argues that forgetting about parental death is a social process through which psychological, economic and social recovery takes place. My findings show an example of such recovery: forgetting among the Ovambo appears to have the intention of helping orphans to resume a normal life as a 'child in a family'. Customs and ideas such as emphasizing that the caregiver is the new parent, and removing the child from the house where it lived with the parent when it is unable to forget the parent seem to function to stimulate the transition from orphan into a child with parents. Hutchinson (2007) describes a similar process within Malawian households. She writes: 'Part of this acceptance of this new relationship is the acceptance of advice given to children by their new carers' (p. 174). 'Children have to acknowledge the new carers as their parents. The new carers take them on and behave as parents, and by doing so the children's identities can shift from being an orphan into not being an orphan' (p. 174-175). Hutchinson (2007) further notes that the new caregivers should treat the orphans well. In my study, similar ideas were found; several caregivers said that orphans should be treated well, and especially some grandmothers indicated that orphans needed, more than the other children in the household, extra care and attention. Hutchinson (2011) advises to respect such (dynamic) local systems of recovery and states that the introduction of Western models, in which verbalising and working through traumatic memories are highly valued, could undermine the psychological recovery that is stimulated by local coping systems. Hutchinson (2011) concludes: 'the creation of a body of

knowledge about local meaning systems through which orphaned children are expected to grieve and recover would be a useful basis upon which projects could be created to support children and the adults who surround them during what is undoubtedly an extremely difficult and challenging time' (p. 26).

Furthermore, I argue that in northern Namibia, some customs seem to help children to deal with parental loss, despite the general emphasis on not expressing grief. For instance, practices of caregivers such as the singing of hymns with the child in the period after the funeral may have a comforting effect. The custom of having children drink water mixed with sand from the grave of the parent, in order to stop children's nightmares about the deceased parent, might reflect that their fears and concerns are taken seriously and given attention. This custom is specific for the Ndonga Ovambo. My data also revealed that Ovambo notions on childhood grief are not static. The fact that caregiver's attitudes with regards to informing orphans about, and involving them in, the death of their parents were subject to change, could indicate a growing awareness for the ways children deal with death and loss. However, it should be noted that several caregivers opposed this development. Among younger caregivers, there was also some recognition that children could stay sad after the funeral, even though children did not show it or talk about it.

Children benefit from discussing parental loss

Whereas the previous can indicate a cultural relativism stance, other scholars claim that cultural beliefs do not necessarily help people to deal with, or make sense of, their grief, and that the same cultural beliefs may affect people in various ways (Hollan, 1995; Brison & Leavitt, 1995). I argue that several factors of my study may indicate that the Ovambo way of dealing with loss are not beneficial for all. First, the ideal picture of the well-treated and supported orphan does not occur in every household, as emerged from the children's stories. This makes it difficult for children to accept and acknowledge their caregivers as their 'new parents', and forget about their deceased parents.

Second, the emphasis on forgetting and the limited communication on parental loss within households, limits children in receiving information or sharing memories about their deceased parent. My data showed, however, that many children find it important to know about their parent's behaviour and

character, their life circumstances and they wished to know their parent's cause of death – most likely in connection with identity issues.

Third, in contemporary Western views on handling childhood grief the premise exists that children and adolescents should be offered the possibility to express their grief, and that they are able to raise questions in relation to the death of their parent (e.g. 'The Department of Social Work,' 1991). For instance, Blin and Jonas-Simpson (2018) note that open communication, nurturing resilience, modeling grief, ritual and commemoration are important in supporting grieving children (p. 41-43). Western studies show that supportive and sensitive caregiver communication was found to help children cope with death (Siegel & Gorey, 1994; Tremblay & Israel, 1998; Raveis, Siegel & Karus, 1999; Shapiro, Howell & Kaplow, 2014; Howell et al. 2016). In South Africa, caregiver-child communication in contexts of adversity was likewise found to have a protective role (Govender et al., 2014). This also emerged in my study: expressing grief and talking about their loss appeared to be helpful for children. During the research evaluation several said that it had 'felt good' to talk about their deceased parents and their loss experiences. Alongside this, most orphans felt that attending the funeral and knowing the site of their parent's grave had been helpful.

Fourth, professionals criticized some Ovambo customs for being counterproductive. They stressed that many orphans do not receive adequate support from caregivers to help them deal with parental loss. A staff member of the NGO Positive Vibes noted that many caregivers lack the skills to talk about death-related issues with children, or caregivers believe that children do not have the right to be informed about such issues (interview, Ongwediva, 2012). A psychologist working in northern Namibia observed that many adults had not gotten over the losses themselves, even deaths which happened 40 years ago, which made them reluctant to address any losses with children (interview, Oshakati, 2011). In Namibia, childhood bereavement is causing distress amongst children, both psychological distress and worry over loss-related family problems such as fights, misuse of grants, and no place to stay, to the extent that they seek help (interview Lifeline/Childline, Windhoek 2013). This was confirmed by the psychologist, who had observed that bereavement was the underlying cause of the majority of problems of the children and adolescents she had worked with. The Positive Vibes staff member likewise experienced that when children did not talk about loss-related hurt, children would continue to carry that burden. Thus, it

appears that children in northern Namibia would benefit from more openness in dealing with, and talking about, parental loss, however, caution is required as this should not interfere with local coping systems.

7.4 POLICY AND PROGRAM RECOMMENDATIONS

7.4.1 Recommendations for bereavement programs

Several children in northern Namibia would most likely profit from talking about parental loss in a family setting, however, as this thesis has shown, their caregivers and remaining parents often avoid doing so due to cultural, personal and practical factors. The communication model presented in my study (see Chapter 4) is useful for bereavement interventions that focus on strengthening communication on loss between caregivers and bereaved children in Namibia, and possibly also for other southern African countries. This model shows the diverse obstructing factors in the communication process. There is a need for understanding the role and function of caregiver-child communication in different contexts to inform the design of interventions (Vaz, Eng, Maman, Tshikandu, Behets, 2010). Furthermore, the positioning of significant adults in bereavement programs tends to be overlooked (Wood, Case & Aggleton, 2006). For instance, the South African Khululeka grievance support program[12] mainly focuses on peer support groups instead. Caregivers should be assisted in dealing with children's grieving by building their capacity to address emotional issues (Wood et al., 2006). Shapiro, Howell and Kaplow (2014) found in their US study that mother-child communication may be a determining factor in children's grief reactions following the death of a father. They state that such communication is an important intervention for families who have suffered a loss. In bereavement interventions which involve remaining parents, this appears to be a positive approach. For example, a study of Cambodian refugees in California reported that programs supporting parents in both overall parenting skills and their own personal encounters with grief seem to promote the most solid foundation of support for their grieving children (Prong, 1995, in Bosticco et al., 2005).

[12] www.khululeka.org

Chapter 4 also describes the challenges and considerations that caregivers experience regarding the disclosure of the HIV positive status of the deceased parent to the child. Organizations or health centers that work with HIV-infected children or with HIV-infected parents who wish to disclose their HIV infection to their children have developed successful strategies. These include a method of gradual or partial HIV disclosure to the child with support from professionals, whereby continuous communication with caregivers and professionals are important to the process leading to complete disclosure (e.g. Lee, 1999). Such knowledge is useful for assisting caregivers in HIV disclosure.

7.4.2 Policy recommendations

Further implications for practice that arise from the findings of my study include the child grants. In Namibia, the child welfare grant system is an important policy to tackle poverty amongst orphaned children in the context of the AIDS epidemic. My findings showed that about half of the orphans did not (fully) benefit from the grant even though they qualified for it. My study describes that government institutions did take various measures to ensure that orphans benefited from the child grant to a greater extent. However, such measures can be improved. Adjustment of the administrative processes in order to make sure that children receive new or duplicate documents is recommended. When documents were missing, elderly caregivers in particular had difficulties finding their way through the application procedures. Therefore, elderly caregivers should receive special support during the application process. Furthermore, the Namibian government must ensure that orphans themselves benefit from the child grant, and that it does not leak to third parties. My findings also showed that for orphans, it was often difficult to address the misuse of the child grant, given the unequal power position between their caregiver and themselves. Furthermore, most orphans refrained from reporting misuse to official boards. Ways for children to report the misuse of their child grant should be made more accessible.

A complicating factor in all this is the vulnerable position of poor non-orphans. Ansell (2016) argues that orphans grants may have negative effects such as that poor non-orphans fail to benefit. The findings of this study offer support for a social protection system that supports all families with children (e.g.

Meintjes, Budlender, Giese & Johnson, 2003; UNICEF, n.d.a) A further negative effect of the orphan grant, Ansell (2016) argues, is that it commodifies children's orphan status. In my study, orphans complained about being asked in class about their orphan status – this as part of the Progress Form teachers have to fill in. It is thus recommended to change this routine, to prevent children from being re-identified as orphans.

Child protection has become an increasing focal point in Namibia. However, the majority of the orphans experienced to some extent an unsafe post-loss home situation. My findings showed that although different state actors addressed child protection in northern Namibia, including the police, social workers, and regional and village leaders, various challenges still exist in providing a sufficient system for child protection especially when it comes to attending the needs of rural children. These included, among others, a lack of social workers and underreporting. The latter is caused by reluctance within the community to report child maltreatment and a focus within the system on the self-reporting of children. Thus, at different levels, structures could be strengthened or developed to improve child protection in northern Namibia.

A set of recommendations to improve child protection in northern Namibia are the following. Examples of support structures at a community and family level are: raising awareness within communities; ensuring the anonymity of community members who report child maltreatment; strengthening parenting capacity; training of the village headman, lay counsellors, school staff and church workers; and providing information about the legal consequences of child abuse. On a child level: the reporting of child abuse by children themselves should be facilitated, such as the appointment of trustworthy community workers to whom children can turn to for confidential help; ensuring a safe school environment so that children feel free to report to teachers; discussing the issue in the school curriculum; appointing more social workers in the region; and strengthening the child helpline. Thus, a multidimensional approach toward child protection must be utilized to ensure a safe home environment for these children. This is not only important for children's general well-being, but might also have positive effects on how they cope with parental loss.

REFERENCES

Aarni, T. (1982). *The Kalunga concept in Ovambo religion from 1870 onwards.* Stockholm: University of Stockholm, Almquist & Wiksell.

Abebe, T. (2009). Multiple methods, complex dilemmas: Negotiating socio-ethical spaces in participatory research with disadvantaged children. *Children's Geographies, 7*(4), 451-465.

Abebe, W., & Teferra, S. (2012). Disclosure of diagnosis by parents and caregivers to children infected with HIV: Prevalence associated factors and perceived barriers in Addis Ababa, Ethiopia. *AIDS Care, 24*(9), 1097-1102.

Akwara, P. A., Noubary, B., Lim Ah Ken, P., Johnson, K., Yates, R., Winfrey, W., … Luo, C. (2010). Who is the vulnerable child? Using survey data to identify children at risk in the era of HIV and AIDS. *AIDS Care, 22*(9), 1066-1085.

Andersson, N., Ho-Foster, A., Mitchell, S., Scheepers, E., & Goldstein, S. (2007). Risk factors for domestic physical violence: National cross-sectional household surveys in eight southern African countries. *BMC Women's Health, 7*, 11.

Anema, A., Au-Yeung, C. G., Joffres, M., Kaida, A., Vasarhelyi, K., Kanters, S., Montaner, J. S., & Hogg, R. S. (2011). Estimating the impact of expanded access to antiretroviral therapy on maternal, paternal and double orphans in sub-Saharan Africa, 2009-2020. *AIDS Research and Therapy, 8*, 13.

Annan, A. Kofi (2001). Forword. In: R. McRae & D. Hubert (Eds.), *Human Security and the New Diplomacy. Protection people, promoting peace* (p. xix-xx). Montreal and Kingston, London, Ithaca: McGill-Queen's University Press.

Ansell, N. (2016). 'Once upon a time…': Orphanhood, childhood studies and the depoliticisation of childhood poverty in southern Africa. *Childhood, 23*(2), 162-177.

Arnold, C. (2018). Introduction. In C. Arnold (Ed.), *Understanding child and adolescent grief: Supporting loss and facilitating growth* (pp. 1-6). London - New York: Routledge.

Ashforth, A. (2002). An epidemic of witchcraft? The implications of AIDS for the post-apartheid state. *African Studies, 61*(1), 121-143.

Astuti, R., & Harris, P. L. (2008). Understanding mortality and the life of the ancestors in rural Madagascar. *Cognitive Science: A Multidisciplinary Journal, 32*, 713-740.

Astuti, R., Solomon, G.E.A., & Carey, S. (2004). Constraints on conceptual development: A case study of the acquisition of folk biological and folk sociological knowledge in Madagascar. *Monographs of the Society for Research in Child Development, 69*(3), i-161.

Ayuku, D., Embleton, L., Koech, J., Atwoli, L., Hu, L., Ayaya, S., … Braitstein, P. (2014). The government of Kenya cash transfer for orphaned and vulnerable children: Cross-sectional comparison of household and individual characteristics of those with and without. *BMC International Health and Human Rights, 14,* 25.

Baddely, J., & Singer, J.A. (2010). A loss in the family: Silence, memory, and narrative identity after bereavement. *Memory, 18*(2), 198-207.

Badoe, E. (2017). A critical review of child abuse and its management in Africa. *African Journal of Emergency Medicine, 7,* S32-S35.

Barenbaum, E., & Smith, T. (2016). Social support as a protective factor for children impacted by HIV/AIDS across varying living environments in southern Africa. *AIDS CARE, 28*(S2), 92-99.

Bastien, S., Kajula, L.J., & Muhwezi, W.W. (2011). A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health, 8*(25), 1-17.

Battaglia, D. (1992). The body in the gift: Memory and forgetting in Sabarl mortuary exchange. *American Ethnologist, 19*(1), 3-18.

Becker, H. (2005). 'It all depends on the family': Revisiting laws and practices of inheritance in Namibia. In Legal Assistance Centre (Ed.), *The meanings of inheritance: Perspectives on Namibian inheritance practices* (pp. 93-104). Windhoek: Gender Research & Advocacy Project, Legal Assistance Centre.

Behr, D., Haer, R., & Kromrey, D. (2015). What is a chief without land? Impact of land reforms on power structures in Namibia. *Regional and Federal Studies, 25,* 455-472.

Belsky, J. (1980). Child maltreatment: An ecological integration. *American Psychologist, 35*(4), 320-335.

Benedict, C. (2003). The forgotten compass of death: Apocalypse then and now in the social history of South Africa. *Journal of Social History, 37*(1), 199-218.

Berg, L., Rostila, M., & Hjern, A. (2016). Parental death during children and depression in young adults: a national cohort study. *Journal of Child Psychology and Psychiatry, 57*(9), 1092-1098.

Bicego, G., Rutstein, S., & Johnson, K. (2003). Dimensions of the emerging orphan crisis in sub-Saharan Africa. *Social Science & Medicine, 56*(6), 1235–1247.

Bifulco. A., Harris, T., & Brown, G. (1992). Mourning or early inadequate care? Reexamining the relationship of maternal loss in childhood with adult depression and anxiety. *Development and Psychopathology, 4,* 433-449.

Birdthistle, IJ., Floyd S., Mwanasa S., Nyagadza A., Gwiza E., & Glynn J. R. (2010). Child sexual abuse and links to HIV and orphanhood in urban Zimbabwe. *Journal of Epidemiology and Community Health, 65*(12), 1075-1082.

Bledsoe, C. H. (1990). No success without struggle: Social mobility and hardship for foster children in Sierra Leone. *Man, 25*(1), 70-88.

Bledsoe, C. H., Ewbank, D. C., & Isiugo-Abanthe, U.C. (1988). The effect of child fostering on feeding practices and access to health services in rural Sierra Leone. *Social Science & Medicine, 27*(6), 627-636.

Blagbrough, J. (1998). Collecting information from child domestic workers: Some ethical issues. In V. Johnson, E. Ivan-Smith, G. Gordon, P. Pridmore, & P. Scott (Eds.), *Stepping Forward: Children and Young People's Participation in the Developing Process* (pp. 36-41). London: Intermediate Technology Publications.

Bluebond-Langner, M., & Korbin, J. E. (2007). Challenges and opportunities in the anthropology of childhoods: An introduction to "Children, Childhoods, and Childhood Studies". *American Anthropologist, 109*(2), 241 – 246.

Bond, V., Chase, E., & Aggleton, P. (2002). Stigma, HIV/AIDS and prevention of mother-to-child transmission in Zambia. *Evaluation and Program Planning, 25*(4), 347-356.

Bonnano, G.A. (2004). Loss, trauma and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), 20-28.

Bonnano, G. A., & Field, N. P. (2001). Examining the delayed grief hypothesis across five years of bereavement. *American Behavioral Scientist, 44*, 798-806.

Bonoti, F., Leonardi, A., & Mastora, A. (2013). Exploring children's understanding of death: Through drawings and the death concept questionnaire. *Death Studies, 37*(1), 47-60.

Boon, H., Ruiter, R.A., James, S., Van den Borne, B., Williams, E., & Reddy, P. (2010). Correlates of grief among older adults caring for children and grandchildren as a consequence of HIV and AIDS in South Africa. *Journal of Aging and Health*, *22*(1), 48-67.

Booysen, F., & Arntz, T. (2002). Children of the storm: HIV/AIDS and children in South Africa. *Social Dynamics: A Journal of African Studies, 28*(1), 170-192.

Bordere, T.C., & Larsen, J.A. (2018). Grief and loss among First Nations and African American youth. In C. Arnold (Ed.), *Understanding child and adolescent grief: Supporting loss and facilitating growth* (pp. 136-146). London - New York: Routledge.

Bosticco, C., & Thompson, T. (2005). The role of communication and story telling in the family grieving system. *Journal of Family Communication, 5*(4), 255-278.

Bowlby, J. (1980). *Loss, sadness and depression*. *Vol. 3. Attachment and loss.* New York: Basic Books.

Bowlby, J. (1982). *Attachment and loss: Vol. I. Attachment* (first published in 1969). New York: Basic Books.

Bowman, T. (1999). Shattered dreams, resiliency, and hope: "Restorying" after loss. *Journal of Personal and Interpersonal Loss*, *4*(2), 179-193.

Bowman, C.G., & Brundige, E. (2014). Child sex abuse within the family in sub-Saharan Africa: Challenges and change in current legal and mental health responses. *Cornell International Law Journal, 47*, 231-297.

Boyden, J. (2004). Anthropology under fire: Ethics, researchers and children in war. In J. Boyden, & J. de Berry (Eds.), *Children and Youth on the Front Line: Ethnography, Armed Conflict and Displacement,* (pp. 237-258). New York - Oxford: Berghahn Books.

Boyden, J. & G. Mann (2005). Children's Risk, Resilience, and Coping in Extreme Situations. In M. Ungar. (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 3-25). Thousand Oaks – London - New Delhi: Sage Publications.

Bozolli, C. (2010). *A Lost Generation? Long Term Socioeconomic Outcomes in Orphans.* DIW Discussion Papers, No. 1069. Berlin: Deutsches Institut für Wirtschaftsforschung (DIW). Retrieved 2019, August 31 from https://ssrn.com/abstract=1685224

Bracken, P. J. (1998). Hidden agendas: Deconstructing Post Traumatic Stress Disorder. In P. J. Bracken, & C. Petty (Eds.), *Rethinking the Trauma of War* (pp. 38-59). London: Free Association Books.

Bray, R. (2003). Predicting the social consequences of orphanhood in South Africa. *African Journal of AIDS Research, 2*(1), 39-55.

Brewer, J. D., & Sparkes, A.C. (2011). Young people living with parental bereavement: Insights from an ethnographic study of a UK childhood bereavement service. *Social Science & Medicine, 72*(2), 283-290.

Brison, K. J. (1995). You will never forget: narrative, bereavement, and worldview among Kwanga women. *Ethos, 23*(4), 474-488.

Brison, K. J., & Leavitt, S.C. (1995). Coping with bereavement: Long-term perspectives on grief and mourning. *Ethos, 23*(4), 395-400.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, Mass.: Harvard University Press

Brown, E.J., Amaya-Jackson, L., Cohen, J., Handel, S., Thiel De Bocanegra, H., Zatta, E., … Mannarion, A. (2008). Childhood traumatic grief: A multi-site empirical examination of the construct and its correlates. *Death studies, 32(*10), 899-923.

Brown, J. (2009). Child fosterage and the developmental markers of Ovambo children in Namibia: A look at gender and kinship. *Childhood in Africa, 1*(1), 4-10.

Brown, J. (2011). Child fostering chains among Ovambo families in Namibia, Southern Africa. *Journal of Southern African Studies,* 37(1), 155-176.

Brown, D. W., Riley, L., Butchart, A., Meddings, D. R., Kann, L., & Phinney Harvey, A. (2009). Exposure to physical and sexual violence and adverse health behaviours in African children: Results from the Global School-based Student Health Survey. *Bulletin World Health Organization, 87*, 447-455.

Campbell, C., Skovdal, M., Mupambireyi, Z., & Gregson, S. (2010). Exploring children's stigmatization of AIDS-effected children in Zimbabwe through stories and drawings. *Social Science & Medicine, 71*(5), 975-985.

Carelse, V. (2018). *Namibia's success in the fight against HIV. BBC. 1 December 2018*. Retrieved 2019, August 6 from https://www.bbc.com/news/world-africa-46397877

Case, A., & Ardington, C. (2006). The impact of parental death on school outcomes: Longitudinal evidence from South Africa. *Demography, 43*(3), 401-420.

Case, A., Paxson, C., & Ableidinger, J. (2004). Orphans in Africa: Parental death, poverty, and school enrollment. *Demography, 41*(3), 483–508.

Centraal Bureau voor de Statistiek (CBS) (n.d.). Retrieved 2019, August 6 from https://www.cbs.nl/nl-nl/nieuws/2013/32/jaarlijks-verliezen-ruim-6-duizend-minderjarige-kinderen-een-of-beide-ouders

Central Bureau of Statistics (CBS) (2008). *A Review of Poverty and Inequality in Namibia.* Windhoek, Namibia: National Planning Commission, Central Bureau of Statistics. Retrieved 2019, August 1 from https://d3rp5jatom3eyn.cloudfront.net/cms/assets/documents/p19dmr33n31i1b1ko1f0016hg1jdq1.pdf

Chan, B. T., & Tsai, A. C. (2016). HIV stigma trends in the general population during antiretroviral treatment expansion: Analysis of 31 countries in sub-Saharan Africa, 2003-2013. *Journal of Acquired Immune Deficiency Syndromes, 72*(5), 558-564.

Charmaz, K., & Milligan, M.J. (2006). Grief. In J.E. Stets, & J.H. Turner (Eds.), *Handbook of the Sociology of Emotion* (pp. 516-543). Westport, CT: Greenwood Press.

Cheney, K., (2010). Expanding vulnerability, dwindling resources: Implications for orphaned futures in Uganda. *Childhood in Africa, 2*(1), 8–15.

Cheney, K. (2011). Children as ethnographers: Reflections on the importance of participatory research in assessing children's needs. *Childhood, 18*(2), 166-179.

Christ, G.H., Siegel, K., Freund, B., Langosch, D., Hendersen, S., Sperber, D., & Weinstein, L. (1993). Impact of parental terminal cancer on latency-age children. *American Journal of Orthopsychiatry, 63*(3), 417-425.

Christensen, P. (2004). Children's participation in ethnographic research: Issues of power and representation. *Children and Society, 18*(2), 165-176.

Christensen, P., & James, A. (1999). Introduction: Researching children and childhood: Cultures of communication. In P. Christensen, & A. James (Eds.), *Research with children: Perspectives and practices* (pp. 1-8). London: Falmer Press.

Christensen, P., & James, A. (2008). Introduction: Researching children and childhood: Cultures of communication. In P. Christensen, & A. James (Eds.), *Research with Children: Perspectives and Practices* (2nd ed.) (pp. 1-9). London - New York: Routledge.

Christiansen, C., Utas, M., & Vigh, M. (2006). Introduction. In C. Christiansen, M. Utas, & M. Vigh (Eds.), *Navigating youth, generating adulthood: Social becoming in an African context* (pp. 9-28). Stockholm: ElandersGotab AB.

Clacherty, G., & Donald, D. (2007). Child participation in research: Reflections on ethical challenges in the southern African context. *African Journal of AIDS Research,6*(2), 147-156.

Cluver, L., & Gardner F. (2006). The psychological well-being of children orphaned by AIDS in Cape Town, South Africa. *Annals of General Psychiatry, 5*, 8.

Cluver, L., Gardner, F., & Operario, D. (2007). Psychological distress amongst AIDS-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry, 48*(8), 755–763.

Cluver, L., Meinck, F., Yakubovich, A., Doubt, J., Redfern, A., Ward, C., … Gardner, F. (2016). Reducing child abuse amongst adolescents in low- and middle-income countries: A pre-post trial in South Africa. *BMC Public Health, 16*(1), 567.

Cluver L., Orkin M., Boyes M., Gardner F., & Meinck F. (2011). Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty. *Journal of Acquired Immune Deficiency Syndromes, 58*(3), 336-343.

Cocks, A. (2006). The ethical maze: Finding an inclusive path towards gaining children's agreement to research participation. *Childhood, 13*(2), 247-266.

Cook, A.S. (1995). Ethical issues in bereavement research: An overview. *Death Studies*, *19*(2), 103-122.

Cook A.S., & Bosley, G. M. (1995). The experience of participating in bereavement research: Stressful or therapeutic? *Death Studies*, *19*(2), 157-170.

Collishaw, S., Gardner, F., Aber, J.L., & Cluver, L. (2015). Predictors of mental health resilience in children who have been parentally bereaved by AIDS in urban South Africa. *Journal of Abnormal Child Psychology, 44*(4), 719-730.

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry, 9*(3), 335-354.

Corden, A., & Hirst, M. (2008). Implementing a mixed methods approach to explore the financial implications of death of a life partner. *Journal of Mixed Methods Research, 2*(3), 208-220.

Corden, A., Sloper, P., & Sainsbury, R. (2002). Financial effects for families after the death of a disabled or chronically ill child: A neglected dimension of bereavement. *Child: Care, Health and Development, 28*(3), 199-204.

Corsaro, W.A., & Molinari, L. (2008). Entering and observing in children's worlds: A reflection on a longitudinal ethnography of early education in Italy. In P. Christensen,

& A. James (Eds.), *Research with Children. Perspectives and Practices* (pp. 239-259). London - New York: Routledge.

Cowles, K. V. (1996). Cultural perspectives of grief: An expanded concept analysis. *Journal of Advanced Nursing, 23*(2), 287-294.

Crivello, G., Camfield, L., & Woodhead, M. (2009). How can children tell us about their wellbeing? Exploring the potential of participatory research approaches with Young Lives. *Social Indicators Research, 90*(1), 51-72.

Crivello, G., & Chuta, N. (2012). Rethinking orphanhood and vulnerability in Ethiopia. *Development in Practice, 22*(4), 536-548.

Dane, B. O., & Miller, S. O. (1992). *AIDS: Intervening with hidden grievers.* Westport, CT: Auburn House.

Danese, A., Moffitt, T. E., Harrington, H., Milne, B. J., Polanczyk, G., Pariante, C. M., & Caspi A. (2009). Adverse childhood experiences and adult risk factors for age-related disease: Depression, inflammation, and clustering of metabolic risk markers. *Archives of Pediatrics & Adolescent Medicine, 163*(12), 1135–1143.

Daniel, M. (2005). Beyond liminality: Orphanhood and marginalization in Botswana. *African Journal of AIDS Research, 4*(3), 195-204.

Daniel, M. (2005a). *Hidden Wounds: Orphanhood, Expediency and Cultural Silence in Botswana.* Norwick, UK: School of Development Studies, University of East Anglia.

Daniel, M., Apila, M.A., Bjørgo, R., & Lie, G.T. (2007). Breaching cultural silence: Enhancing resilience among Ugandan orphans. *African Journal of AIDS Research, 6*(2), 109-120.

Dawes, A. and Donald, D (2005). *Improving children's chances: linking developmental theory and practice. Children & Poverty Working Paper 2.* Retrieved August 31, 2019 from https://www.childfund.org/uploadedFiles/public_site/media/publications/program_docs/Improving_Children_s_Chances.pdf

Deininger, K., Garcia, M., & Subbarao, K. (2003). AIDS-induced orphanhood as a systemic shock: Magnitude, impact, and program interventions in Africa. *World Development, 31*(7), 1201–1220.

Delaplace, G. (2010). A sheep herder's rage: Silence and grief in contemporary Mongolia. *Ethnos: Journal of Anthropology, 74*(4), 514-534.

DeMaso, D.R., Meyer, E.C., & Beasley, P.J. (1997). What do I say to my surviving children? *Journal of the Academy of Child and Adolescent Psychiatry, 36*(9), 1299-1302.

Dematteo, D., Harrison, C., Arneson, C., Goldie, R.S., Lefebvre, A., Read, S.E., & King, S.M. (2002). Disclosing HIV/AIDS to children: The paths families take to truthtelling. *Psychology, Health and Medicine, 7*(3), 339-356.

Demmer, C. (2006). Confronting AIDS-related loss and grief: An exploratory study of professional caregivers in KwaZulu-Natal, South Africa. *African Journal of AIDS Research, 5(2),* 97-107.

Demmer, C. (2007). Responding to AIDS-related bereavement in the South African context. *Death Studies, 31*, 821-843.

Demmer, C. (2009). Adolescents and HIV/AIDS. In D. E. Balk, & C. A. Corr (Eds.), *Adolescent encounters with death, bereavement and coping* (pp. 99-114). New York: Springer Publishing company.

Demmer, C., & Rothschild, N. (2011). Bereavement among South African adolescents following a sibling's death from AIDS. *African Journal of AIDS Research, 10*(1), 15-24.

Denis, P. (2005). Memory work and resilience. In P. Denis (Ed.), *Never too small to remember: Memory work and resilience in times of AIDS* (pp. 35-40). Pietermaritzburg: Cluster Publications.

Denis, P. (2009). Are Zulu children allowed to ask questions? Silence, death and memory in the time of AIDS. In B. Carton, J. Sithole, & J. Laband (Eds.), *Being Zulu, Contested Identities Past and Present* (p. 1-14). Retrieved June, 8, 2016 from http://www.kznhass-history.net/files/seminars/Denis2003.pdf.

The Department of Social Work (1991). *Your parent has died*. The Department of Social Work, St. Christopher's Hospice. London: St. Christopher's Hospice.

Doka, K. J. (1999). Disenfranchished grief. *Bereavement Care, 18*(3), 37-39.

Dowdney, L. (2000). Annotation: Childhood bereavement following parental death. *Journal of Child Psychology and Psychiatry, 41*(7), 819-830.

Duffy, L. (2005). Suffering, shame, and silence: The stigma of HIV/AIDS. *Journal of the Association of Nurses in AIDS Care, 16*(1), 13-20.

Durkheim, E. (1952). *Suicide: A study in sociology* (J.A. Spaulding & George Simpson Trans.). London: Routledge and Kegan Paul.

Dyregrov, K. (2004). Bereaved parents' experience of research participation. *Social Science & Medicine, 58*(2), 391-400.

Earls, F., Raviola, G. J., & Carlson, M. (2008). Promoting child and adolescent mental health in the context of the HIV/AIDS pandemic with a focus on sub-Saharan Africa. *Journal of Child Psychology and Psychiatry, 49*(3), 295-312.

Einarsdóttir, J. (2004). *Tired of Weeping: Mother Love, Child Death, and Poverty in Guinea-Bissau.* Madison, Wisconsin: University of Wisconsin.

Englund, H. (1998). Death, trauma and ritual: Mozambican refugees in Malawi. *Social Science & Medicine, 46*(9), 1165-1174.

Eriksen T. H. (2005). *Risking Security: Paradoxes of Social Cohesion.* Inaugural lecture, VU University Amsterdam, 15 March 2005.

Eriksen, T. H. (2018). Globalization. In H. Wydra & B. Thomassen (Eds.), *Handbook of Political Anthropology* (pp. 462-476). Cheltenham - Northampton: Edward Elgar Publishing.

Evers, S. J.T.M., Notermans, C., & Van Ommering, E. (2011). Ethnographies of children in Africa: Moving beyond stereotypical representations and paradigms. In S. J.T.M. Evers, C. Notermans, & E. Van Ommering (Eds.), *Not just a victim: The child as catalyst and witness of Contemporary Africa* (pp. 1-20). Leiden - Boston: Brill.

Evers, S. J. T. M., Vadeboncoeur, J. A., & Weber, B. (2015). Situating children's rights in cultural perspectives on childhood: Intermedial dialogue. *The Canadian Journal of Children's Rights*, *2*(1), 48-71.

Eyber, C., & Ager, A. (2004). Researching young people's experiences of war: Participatory methods and the trauma discourse in Angola. In J. Boyden & J. de Berry (Eds.), *Children and youth on the front line: Ethnography, armed conflict and displacement* (pp. 189-208). New York - Oxford: Berghahn Books.

Faculty of Social Sciences, department of Social and Cultural Anthropology (2005). *Constructing Human Security in a Globalising World (CONSEC)*. Summarized Program Description, August 2007. Amsterdam: Vrije Universiteit Amsterdam.

Fenster, J. (2009). Challenges to tracking subjects for follow-up research: A case study. *Child Welfare, 88*(4), 57-75.

Field, N.P., Hart, D., & Horowitz, M. J. (1999). Representations of self and other in conjugal bereavement. *Journal of Social and Personal Relationships*, *16*(3), 407-414.

Fine, G.A., & Sandstrom, K. L. (1988). *Knowing children: Participant observation with minors*. London - New Delhi: Sage Publications.

Food and Agricultural Organization (FOA) (2010). *World programme for agricultural censuses, A system of integrated agricultural consensuses and surveys, 1.* Rome: World Programme for the Census of Agriculture 2010, Food and Agricultural Organization of the United Nations.

Foster, G. (2002). Beyond education and food: Psychosocial well-being of orphans in Africa. *Acta Paediatrica 91,* 502-504.

Fox, T. (2002). The culture(s) of AIDS, cultural analysis and new policy approaches for Namibia. In V. Winterfelt, T. Fox, P. Mufune (Eds.), *Namibia Society Sociology* (pp. 317-331). Windhoek: University of Namibia Press.

Freud, S. (1957). Mourning and Melancholia. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (vol 14, pp. 152-170). London: Hogarth Press. (Original work published 1917.)

Garenne, M., & Zwang, J. (2006). Premarital fertility in Namibia: Trends, factors and consequences. *Journal of Biosocial Science*, 38, 145-167.

Gartley, W. & Bernasconi, M. (1967). The concept of death in children. *Journal of Genetic Psychology, 110*, 71-85.

Gewald, J.B. (2003). Near death in the streets of Karibib: Famine, migrant labour and the coming of Ovambo to Central Namibia. *The Journal of African History*, *44*(2), 211-239.

Gilbert, L. (2016). 'The mercurial piece of the puzzle': Understanding stigma and HIV/AIDS in South Africa. *Journal of Social Aspects of HIV/AIDS, 13*(1), 8-16.

Gilles, C. M. (2006). "Seeing the difference": An interdisciplinary approach to death, dying, humanities and medicine. *Journal of Medical Humanities, 27*(2), 105-115.

Glaser, D. (2002). Emotional abuse and neglect (psychological maltreatment): A conceptual framework. *Child Abuse and Neglect, 26*(6-7), 697-714.

Goffmann, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York: Simon & Schuster.

Goody, J. (1962). *Death, property and the ancestors: A study of the mortuary customs of the LoDagaa of West Africa.* Stanford: Stanford University Press.

Govender, K., Reardon, C., Quilan, T., & George, G. (2014). Children's psychosocial wellbeing in the context of HIV/AIDS and poverty: A comparative investigation of orphaned and non-orphaned children living in South Africa. *BMC Public Health, 14,* 615.

Gross, R. (2018). *The psychology of grief*. London - New York: Routledge.

Guillemin, M. (2004). Understanding illness: Using drawings as a research method. *Qualitative Health Research, 14*(2), 272-289.

Hampshire, K., Porter, G., Agblorti, S, Robson, E., Munthali, A., & Abane, A. (2015). Context matters: Fostering, orphanhood and schooling in sub-Saharan Africa. *Journal of Biosocial Science, 47*, 141-164.

Hardman, C. (2001) *(1973).* Can there be an anthropology of children? *Childhood, 8*(4), 501-517.

Harkness, S., & Super, C.M. (1977). Why African children are so hard to test. *Annals of the New York Academy of Sciences, 285*(1), 326-331.

Harms, S., Jack, S., Ssebunnya, J., & Kizza, R. (2010). The orphaning experience: Descriptions from Ugandan youth who have lost parents to HIV/AIDS. *Child and Adolescent Psychiatry and Mental Health, 4*(6), 1-10.

Harrison L., & Harrison, R. (2001). Adolescents' bereavement experiences: Prevalence, association with depressive symptoms, and use of services. *Journal of Adolescence, 24*(2), 159-169.

Hemer, S. R. (2010). Grief as a social experience: Death and bereavement in Lihir, Papua New Guinea. *The Australian Journal of Anthropology, 21*(3), 281-297.

Henderson, P.C. (2006). South African Aids orphans: Examining assumptions around vulnerability from the perspective of rural children and youth. *Childhood, 13*(3), 303-327.

Hertz, R. 1960 (1907). *Death and the right hand.* Glencoe, IL: Free Press.

Heywood, C. (2018). *A history of childhood: Children and childhood in the West from medieval to modern times* (second edition, fully revised and expanded. First edition 2001). Cambridge - Malden: Polity Press.

Hill, M. (2005). Ethical considerations in researching children's experiences. In S. Greene, & D. Hogan (Eds.), *Researching children's experience: Methods and approaches* (pp. 61-86). London - Thousand Oaks - New Delhi: Sage Publications.

Hiltunen, M. (1993). *Good magic in Ovambo*. Helsinki: The Finnish Anthropological Society.

Himmebauch, A., Arnold, R.M., & May, C. (2008). Grief in children and developmental concepts of death. *Journal of Palliative Medicine, 11*, 242-244.

Hockey, J., & James, A. (1993). *Growing up and growing old.* London: Sage Publications.

Hockey, J. (2001). Changing death rituals. In J. Hockey, J. Katz, & N. Small (Eds.), *Grief, mourning and death ritual* (pp.185-211). Buckingham, UK: Open University Press.

Hollan, D. (1995). To the afterworld and back: Mourning and dreams of the dead among the Toraja. *Ethos, 23*(4), 424-436.

Hollan, D. (2009). The influence of culture on the experience and interpretation of disturbing dreams. *Culture, Medicine and Psychiatry, 33*, 313-322.

Holzemer, W.L., Uys, L., Makoae, L., Stewert, A., Phetlhu, A., & Dlamini, P.S. (2007). A conceptual model of HIV/AIDS stigma from five African countries. *Journal of Advanced Nursing, 58*(6), 541-551.

Hoppe, M.J., Wells, E. A., Morrison, D. M., & Gillmore, M. R. (1995). Using focus groups to discuss sensitive topics with children. *Evaluation Review, 19*(1), 102-114.

Howard, B., Matinhure, N., McCurdy, S.A., & Johnson, C.A. (2006). Psychosocial disadvantage: Preparation, grieving, remembrance and recovery for orphans in eastern Zimbabwe. *African Journal of AIDS Research, 5*(1), 71-83.

Howell, K.H., Barret-Becker, E.P., Burnside, A.N., Wamser-Nanney, R., Layne, C.M., & Kaplow, J.B., (2016). Children facing parental cancer versus parental death: The buffering effects of positive parenting and emotional expression. *Journal of Child and Family Studies, 25*, 152-164

Hutchinson, E. (2007). *Private loss, public gain: Orphans in Malawi.* London: University College.

Hutchinson, E. (2011). The psychological well-being of orphans in Malawi: "Forgetting" as a means of recovering from parental death. *Vulnerable Children and Youth Studies, 6*(1), 18-27.

Hyde, A., Howlett, E., Brady, D., & Drennan, J. (2005). The focus group method: Insights from focus group interviews on sexual health with adolescents. *Social Science & Medicine, 61*(12), 2588-2599.

Ingold, T. (2002). Introduction to culture. In T. Ingold (ed.). Companion Encyclopedia of Anthropology: Humanity, culture and social life (pp. 329-349). London - New York: Routlegde.

Institute for Health Metric and Evaluation (IHME) (n.d.). *Namibia*. Retrieved 2019, August 6 from http://www.healthdata.org/namibia

Jakoby, N. R. (2012). Grief as a social emotion: Theoretical perspectives. *Death Studies, 36*(8), 679-711.

James, A. (2001). Ethnography in the study of children and childhood. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of Ethnography* (pp. 247-257). London: Sage Publications

James, A. & Prout, A. (Eds.) (1990*). Constructing and reconstructing childhood*. London: Falmer

James, A. & Prout, A. (Eds.) (2015). *Constructing and reconstructing childhood. Contemporary issues in the sociological study of childhood.* London - New York: Routledge.

Johnson, G. A., Pfister, A. E., & Vindrola-Padros, C. (2012). Drawings, photos, and performances: Using visual methods with children. *Visual Anthropology Review, 28*(2), 164-178.

Joint United Nations programme on HIV/AIDS (UNAIDS) (2018). *Data 2018: UNAIS 2018 reference.* Retrieved 2019, March 10 from https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf

Joint United Nations programme on HIV/AIDS UNAIDS (n.d.) *Namibia. Country Factsheet*. Retrieved 2019, August 5 from https://www.unaids.org/en/regionscountries/countries/namibia.

Kagee, A. (2004). Present concerns of survivors of human rights violations in South Africa. *Social Science & Medicine, 59*(3), 625-635.

Kaplow, J. B., Layne, C. M., Pynoos, R. S., Cohen, J., & Lieberman, A. (2012). DSM-V diagnostic criteria for bereavement-related disorders in children and adolescents: Developmental considerations. *Psychiatry*, 75(3), 242–265.

Kaplow, J. B., Saunders, J., Angold, A., & Costello, E. (2010). Psychiatric symptoms in bereaved versus non-bereaved youth and young adults: A longitudinal, epidemiological study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49,* 1145–1154.

Karpel, M.A. (1980). Family Secrets: I. Conceptual and ethical issues in the relational context. II. Ethical and practical considerations in therapeutic management. *Family Processes, 19*(3), 295-306.

Kaufman, S. R., & Morgan, L. M. (2005). The anthropology of the beginnings and ends of life. *Annual Review of Anthropology*, *34*, 317-341.

Kenyon, B. L. (2001). Current research in children's conceptions of death: A critical review. *Omega, Journal of Death and Dying, 43*(1), 63-91.

Kidman, R., & Palermo, T (2016). The relationship between parental presence and child sexual violence: Evidence form thirteen countries in sub-Saharan Africa. *Child abuse and Neglect, 51*, 172-180.

Kirk, S. (2007). Methodological and ethical issues in conducting qualitative research with children and young people: A literature review. *International Journal of Nursing Studies, 44*(7), 1250-1260.

Kiš, A.D. (2008). An analysis of the impact of Aids on funeral culture in Malawi. *NAPA Bulletin, 27 (1)*, 129-140.

Klass, D. (1999). Developing a cross-cultural model of grief: The state of the field. *Omega, 39*(3), 153-178.

Klass, D. (2002). *Grief and mourning in a cross-cultural perspective*. Macmillian Encyclopedia of death and dying. The Gale Group Inc. Retrieved 2019, August 6 from https://www.encyclopedia.com/social-sciences/encyclopedias-almanacs-transcripts-and-maps/grief-and-mourning-cross-cultural-perspective

Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.) (1996). *Continuing bonds: New understandings of grief.* New York - Abingdon: Routledge.

Kopytoff, I. (1986). The cultural biography of things: Commoditization as process. In A. Appadurai (Ed.), *The social life of things: Commodities in cultural perspective* (pp. 64-91). Cambridge: Cambridge University Press.

Korbin, J. (Ed.). (1981) *Child abuse and neglect: cross-cultural perspectives.* Berkeley: University of California Press

Korbin, J. (1987). Child maltreatment in cross-cultural perspective: Vulnerable children and circumstances. In R.J. Gelles & J.B. Lancaster (Eds.), *Child abuse & Neglect: Biosocial dimensions* (pp.31-55). New York: Aldine de Gruyter.

Kübler-Ross, E. (1970). *On death and dying*. London: Tavistock Publications

Kuo, C., & Operario, D. (2011). Health of adults caring for orphaned children in an HIV endemic community in South Africa. *AIDS Care, 23*(9), 1128–1135.

Lalande, K., & Bonnano, G. (2006). Culture and continuing bonds: a prospective comparison of bereavement in the United States and the People's republic of China. *Death Studies, 30*(4), 303-324.

Lagare, C.H., Evans, E.M., Rosengren, K., & Harris, P. (2009). *The co-existence of scientific and religious explanations across cultures and development: The case of origins, illness and death.* CDSP proposal.

Lambek, M., & Antze, P. (1996). Introduction: Forecasting memory. In P. Antze & Lambek, M. (Eds.), *Tense past: Cultural essays in trauma and memory* (pp. xi-xxviii). New York: Routledge.

Lancy, D. F. (2008). *The anthropology of childhood: Cherubs, chattel, changelings.* Cambridge: Cambridge University Press.

Lancy, D.F. (2012). Unmasking Children's Agency. *Sociology, Social Work and Anthropology Faculty Publications. Paper 277*. Retrieved 2019, August 31 from https://digitalcommons.usu.edu/sswa_facpubs/277

Laungani, P., & Young, B. (1997). Conclusions I: Implications for practice and policy. In C. M. Parkes, P. Laungani, & B. Young (Eds.), *Death and Bereavement Across Cultures* (pp. 218-232). London - New York: Routledge.

Leavitt, S. C. (1995). Seeking gifts from the dead: Long-term mourning in a Bumbita Arapesh cargo narrative. *Ethos, 23*(4), 453-473.

Lee, C. & R. Johann-Liang (1999). Disclosure of HIV/AIDS to children born of HIV-infected mothers. *AIDS patient care and STDs, 13*(1), 41-45

Lee, R., & Vaughan, M. (2012). Introduction: Themes in the study of death and loss in Africa. *African Studies, 71*(2), 163-173.

Lee, R.M., & Renzetti, C.M. (1990). The problems of researching sensitive topics: An overview and introduction. *American Behavioral Scientist, 33*(5), 510-528.

Legal Assistance Centre (LAC). (2012). *Seeking safety: Domestic violence in Namibia and the combating of domestic violence, Act 4 of 2003.* Windhoek: John Meindert Printing (Pty) Ltd.

Leta, T.H., Sandøy, I.F., & Fylkesnes, K. (2012). Factors affecting voluntary HIV counselling and testing among men in Ethiopia: A cross-sectional survey. *BMC Public Health,* 12, 438.

LeVine, R.A. (1997). Culture and personality. In T. Barfield (Ed.), *The dictionary of anthropology* (pp. 101-103). Oxford, Malden: Blackwell publishers.

LeVine, R.A. (2007). Ethnographic studies of childhood: A historical overview. *American Anthropologist, 109*(2), 247-260.

LeVine, R., Dixon, S., LeVine, S., Richman, A., Liederman, H., Keefer, C., & Brazelton, T. (1994). *Child care and culture: Lessons from Africa.* Cambridge: Cambridge University Press.

Levine, S., Van der Berg, S., & Yu, D. (2011). The impact of cash transfers on household welfare in Namibia. *Development Southern Africa, 28*(1), 39-59.

Li, X., Naar-King, S., Barnett, D., Stanton, B., Fang, X., & Turston, C. (2008). A developmental psychopathology framework of the psychosocial needs of children orphaned by HIV. *Journal of the Association of Nurses in AIDS Care, 19*(2), 147-157.

Lifeline/Childline Namibia. (2007). *Annual Report, 2006-2007.* Windhoek: Lifeline/Childline Namibia.

Link, B.G., & Phelan, J. (2014). Stigma power. *Social Science & Medicine, 103,* 24-32.

Lipponen, L, Rajala, A., Hilppö, J., & Paananen, M. (2016). Exploring the foundations of visual methods used in research with children. *European Early Childhood Education Research Journal, 24*(6), 936-946.

Lofland, L. H. (1985). The social shaping of emotion: The case of grief. *Symbolic Interaction, 8*(2), 171–190.

Logie, C., & Gadalla, T.M. (2009). Meta-analysis of health and demographic correlates of stigma towards people living with HIV. *AIDS Care, 21*(6), 742-753.

Luttrell, W. (2010). 'A camera is a big responsibility': A lens for analyzing children's visual choices. *Visual Studies, 25*(3), 224-237.

Lutz, C., & White, G.M. (1986), The Anthropology of Emotions. *Annual Review of Anthropology, 15,* 405-436.

Macedo, A., Sherr, L., Tomlinson, M., Skeen, S., & Roberts K. (2018). Parental bereavement in young children living in South Africa and Malawi: Understanding mental health resilience. *Journal of Acquired Immune Deficit Syndrome, 78*, 390-398.

Madhavan, S. (2004). Fosterage patterns in the age of AIDS: Continuity and change. *Social Science & Medicine, 58*(7), 1443-1454.

Madu, S. (2003). The relationship between parental physical availability and child sexual, physical and emotional abuse: A study among a sample of university students in South Africa. *Scandinavian Journal of Psychology, 44*(4), 311-318.

Makame, V., Ani, C., & Grantham-McGregor, S. (2002). Psychological wellbeing of orphans in Dar El Salaam, Tanzania. *Acta Paediatrica*, *91*(4), 459–465.

Malan, J.S. (1980). The Wambo. In: *The peoples of South West Africa*, (pp.75-92), Pretoria: HAUM Press.

Mann (1987). *Statement at an informal briefing on AIDS to the 42nd session of the United Nations national assembly, 20 October, New York.* New York: World Health Organization. Retrieved 2019, August 31 from http://apps.who.int/iris/bitstream/10665/61546/1/WHO_SPA_INF_87.12.pdf

Mayall, B. (1994). Introduction & Children in action at home and school. In B. Mayall (Ed.), *Children's childhoods observed and experienced* (pp. 1-12 & pp. 115-127). London: Falmer Press.

Mayall, B. (2012). An afterword: some reflections on a seminar series. *Children's Geographies, 10*(3), 347-355.

McClatchey, I.S., Vonk, M. E., Lee, J.,& Bride, B. (2014). Traumatic and complicated grief in children: One or two constructs? *Death Studies, 38*(2), 69-78.

Mdleleni-Bookholane, T., Schoeman, W., & Van der Merwe, I. (2004). The development in the understanding of death among black South African learners from the Eastern Cape, South Africa. *Health SA Gesondheid, 9*(4), 3-14.

Meinck, F., Cluver, L. D., Boyes, M. E., & Mhlongo, E. L. (2015). Risk and protective factors for physical and sexual abuse of children and adolescents in Africa: A review and implications for practice. *Trauma, Violence & Abuse, 16*(1), 81-107

Meinck, F., Cluver, L. D., Boyes, M. E., & Ndhlovu, L. D. (2015a). Risk and protective factors for physical and emotional abuse victimization amongst vulnerable children in South Africa. *Child Abuse Review, 24*(3), 182-197.

Meinck, F., Cluver, L. D., & Boyes, M. E. (2015b). Household illness, poverty and physical and emotional child abuse victimization: Findings from South Africa's first prospective cohort study. *BMC Public Health, 15,* 444.

Meinck, F., Cluver, L. D., Orkin, F. M., Kuo, C., Sharma, A. D., Hensels, I. S., & Sherr, L. (2017). Pathways from family disadvantage via abusive parenting and caregivers mental health to adolescent health risks in South Africa. *Journal of Adolescent Health, 60,* 57-64.

Meintjes, H., Budlender, D., Giese, S., & Johnson, L. (2003*). Children 'in Need of Care' or in Need of Cash? Questioning Social Security Provisions for Orphans in the Context of the South African AIDS Pandemic.* A joint Working Paper. Cape Town : Children's Institute and Centre for Actuarial Research, University of Cape Town. Retrieved 2019, August 31 from https://www.commerce.uct.ac.za/Research_Units/CARE/RESEARCH/PAPERS/FosterCarePaper-final.pdf

Meintjes, H., & Giese, S. (2006). Spinning the epidemic: The making of mythologies of orphanhood in the context of AIDS. *Childhood, 13*(3), 407-430.

Melhem N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F. 3rd, & Brent, D. (2004). Traumatic grief among adolescents exposed to a peer's suicide. *American Journal of Psychiatry, 161*(8), 1411-6.

Melhem, N. M., Porta, G., Shamseddeen, W., Walker Payne, M. & Brent, D. A. (2011). Grief in children and adolescents bereaved by sudden parental death. *Archives of General Psychiatry,68*(9), 911-919.

Melhem, N., Porta, G., Walker Payne, M. & Brent, D.A. (2013). Identifying prolonged grief reactions in children: Dimensional and diagnostic approaches. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(6), 599-607

Mendelsohn, J., El Obeid, S., & Roberts, C. (2000). *A profile of north-central Namibia*. Environmental profiles project, prepared for the Ministry of Environment and Education. Windhoek: Gamsberg Macmillan Publishers.

Metcalf, P., & Huntington, R. (1991). *Celebrations of death. The anthropology of mortuary ritual.* New York: Cambridge University Press.

Miettinen, K. (2005). *On the way to whiteness. Christianization, conflict and change in colonial Ovamboland, 1910-1965.* Helsinki: SuomalaisenKirjallisuudenSeura.

Miller, S.I., & Schoenfeld, L. (1973). Grief in the Navajo: Psychodynamics and culture. *International Journal of Social Psychiatry, 19*(3), 187-191.

Mills, R., Alati, R., O'Callaghan, M., Najman, J. M., Williams, G. M., Bor, W., & Strathearn, L. (2011). Child abuse and neglect and cognitive function at 14 years of age: Findings from a birth cohort. *Pediatrics, 127*(1), 4–10.

Ministry of Gender Equality and Child Welfare (MGECW) (2007). *Namibia National Plan of Action for Orphans and Vulnerable Children. Volume 1.* Windhoek, Namibia: MGECW. Retrieved 2019, August 9 from https://www.unicef.org/infobycountry/files/NPAforOVC-Vol1.pdf

Ministry of Gender Equality and Child Welfare (MGECW) (2010). *The Effectiveness of Child Welfare Grants in Namibia.* Windhoek, Namibia: Ministry of Gender Equality and Child Welfare. Retrieved 2019, August 31 from https://www.unicef.org/namibia/MGECW_2010_Child_Grants_Report_Vol_1_summary.pdf

Ministry of Gender Equality and Child Welfare (MGECW), Legal Assistance Centre (LAC) & UNICEF (n.d.). *The draft child care and protection act – issues for public debate. Booklet 1*. Retrieved 2019, August 8 from http://www.lac.org.na/projects/grap/Pdf/CCPA01-Overview-of-CCPA.pdf.

Ministry of Health and Social Services (MoHSS) (2008). *Report on the Namibia School-based Student Health Survey 2004.* Windhoek, Namibia: Ministry of Health and Social Services.

Ministry of Health and Social Services (MoHSS) (2009). *2008/09 Estimates and Projections of the Impact of HIV/AIDS in Namibia*. Windhoek, Namibia: Ministry of Health and Social Services. Retrieved 2019, August 9 from http://www.data.unaids.org/pub/report/2008/20080915_namibia_estimates_2008_en.pdf

Ministry of Health and Social Services (MoHSS) (2016). *Surveillance report on the 2016 national HIV sentinel survey.* Retrieved 2019, August 6 from http://www.mhss.gov.na/documents/119527/364677/National+HIV+Sentinel+Survey+Report+2016.pdf/0f747cd1-84f6-4360-9586-2ce9131d3ef5

Ministry of Health and Social Services (MoHSS) (2018). *Namibia population-based HIV impact assessment. Namphia 2017*. Summary sheet. Retrieved 2020, February 29 from https://phia.icap.columbia.edu/wp-content/uploads/2018/10/33462%E2%80%A2NAMPHIA-SS_A$_Bv41.pdf

Ministry of Labour and Social Welfare (MoLSW) (2008). *Namibia Child Activities Survey 2005 (NCAS 2005): Report on Analysis.* Windhoek, Namibia: Ministry of Labour and Social Welfare. Retrieved 2019, August 6 from http://www.ilo.org/ipecinfo/product/download.do?type=document&id=27575

Ministry of Labour and Social Welfare (MoLSW) (2010). *Namibia Labour Force Survey 2008: Report of Analysis.* Windhoek, Namibia: Ministry of Labour and Social Welfare

Mitchell, L.M. (2006). Child-centered? Thinking critically about children's drawings as a visual research method. *Visual Anthropology Review, 22*(1), 60-73.

Montgomery, H. (2009). *An introduction to childhood: An anthropological perspective of children's lives.* Chichester: Blackwell.

Morantz, G., Cole, D., Vreeman, R., Ayaya, S., Ayuku, D., & Braitstein, P. (2013). Child abuse and neglect among orphaned children and youth living in extended families in sub-Saharan Africa: What have we learned from qualitative inquiry? *Vulnerable Children and Youth studies: An International Interdisciplinary Journal for Research, Policy and Care, 8*(4), 338-352.

Morgan, M., Gibbs, S., Maxwell, K., & Britten, N. (2002). Hearing children's voices: Methodological issues in conducting focus groups with children aged 7-11 years. *Qualitative Research*, *2*(1), 5-20.

Morrow, V., & Crivello, G. (2015). What is the value of qualitative longitudinal research with children and young people for international development? *International Journal of Social Research Methodology, 18*(3), 267-280.

Murphy, D.A., Steers, W.N., & DelloStritto, M.E. (2001). Maternal disclosure of mother's HIV serostatus to their children. *Journal of Family Psychology, 15*(3), 441-450.

Mushaandja, J., & Ashton, D. (2013). Problems facing orphans in Windhoek, Namibia: Case study about migration, HIV/AIDS and food security. *Journal of Business Management & Social Sciences Research*, *2*(5), 28-35.

Nagler, S., Andropoz, J., & Forsyth, B. (1995). Uncertainty, stigma and secrecy: Psychological aspects of AIDS for children and adolescents. In S. Geballe, J. Greundel, & W. Andiman (Eds.), *Forgotten Children of the AIDS Epidemic.* (pp.71-82). New Haven - New York: Yale University Press.

Nam, S. L., Fielding, K., Avalos, A., Gaolathe, T., Dickinson, D., & Geissler, P. W. (2009). Discussing matters of sexual health with children: What issues relating to disclosure of parental HIV status reveal. *AIDS Care, 21*(3), 389–395.

Namibia Statistics Agency (NSA) (2012). *Child Poverty in Namibia: A Child-centered Analysis of the NHIES 2009/10.* Windhoek, Namibia: Namibia Statistics Agency. Retrieved 2019, August 31 from https://www.unicef.org/esaro/2012-UNICEF-Namibia-Child-Poverty.pdf

Namibia Statistics Agency (NSA) (2012a). *Namibia Household and Income and Expenditure Survey 2009/2010.* Windhoek, Namibia: Namibia Statistics Agency. Retrieved 2019, August 8 from http://cms.my.na/assets/documents/p19dmrae8os57rbnfuvbrgoae1.pdf

Namibia Statistics Agency (NSA) (2012b). *Poverty dynamics in Namibia: A comparative study using the 1993/94, 2003/04 and the 2009/10 NHIES surveys.* Windhoek, Namibia: Namibia Statistics Agency. Retrieved 2019, August 8 from https://d3rp5jatom3eyn.cloudfront.net/cms/assets/documents/p19dnar71kanl1vfo14gu5rpbkq1.pdf

Namibia Statistics Agency (NSA) (2013). *Namibia Labour Force Survey 2012*. Windhoek, Namibia: Namibia Statistics Agency.

Namibia Statistics Agency (2014). *Namibia Demographic Health Survey, 2013.* Windhoek, Namibia: Namibia Statistics Agency, Ministry of Health and Social Services. Retrieved 2019, August 6 from https://dhsprogram.com/pubs/pdf/fr298/fr298.pdf

Namibia Statistics Agency (NSA) and Republic of Namibia (2014a). *Oshana 2011. Census regional profile*. Retrieved 2019, August 6 from https://cms.my.na/assets/documents/p19dptss1qlrdo691ir01l6g3e77.pdf

Nampala, L.T. (2006). Christianisation and cultural change in Nothern Namibia. A comparative study of the impact of Christianity on OuKwanyama, Ondangwa and Ombalantu, 1870-1971. In L.T. Nampala and V. Shigwedha. *Aawambo Kingdoms, history and cultural change. Perspectives from Northern Namibia*. Basel: P. Schlettwein.

N. Scheper-Hughes (1987). Introduction: The cultural politics of child survival. In N. Scheper-Hughes (Ed.), *Child survival: Anthropological perspectives on the treatment and maltreatment of children* (pp. 1-32). Dordrecht: D. Reidel.

National Planning Commission (NPC) (2010). *Children and Adolescents in Namibia 2010: A Situation Analysis.* Windhoek, Namibia: National Planning Commission.

Nichols, J., Embleton, L., Mwangi, A., Morantz, G., Vreeman, R., Ayaya, S., … Braitstein, P. (2014). Physical and sexual abuse in orphaned compared to non-orphaned children in sub-Saharan Africa: A systematic review and meta-analysis. *Child Abuse and Neglect, 38*(2), 304-316.

Neimeyer, R.A. (1999). Narrative strategies in grief therapy. *Journal of Constructivist Psychology, 12*(1), 65-85.

Neimeyer, R. A. (2001). Reauthoring life narratives: grief theory as meaning reconstruction. *Israel Journal of Psychiatry and related Sciences, 38,* 171-183.

Neimeyer, R., Balwin, S., & Gilles, J. (2006). Contuining bonds and reconstruction meaning: mitigating complications in bereavement. *Death Studies, 30*(8), 715-738.

Neimeyer, R. A., Burke, L. A., Mackay, M. M., & Van Dyke Stringer, J. G. (2010). Grief therapy and the reconstruction of meaning: From principles to practice. *Journal of Contemporary Psychotherapy, 40*(2), 73–83.

Nemeroff, C.B. (2016). Paradise lost: The neurobiological and clinical consequences of child abuse and neglect. *Neuron,* 89(2), 892-906.

Niehaus, I. (2007). Death before dying: Understanding AIDS stigma in the South African Lowveld. *Journal of Southern African Studies, 33*(4), 845-860.

Nordanger, D. (2007). Discourses of loss and bereavement in Tigray, Ethiopia. *Culture, Medicine and Psychiatry, 31,* 173-194.

Noret, J. (2012). Grief as a social fact: Notes from southern Benin. *African Studies, 71*(2), 273-286.

Norris, F. H., & Murrell, S.A. (1990). Social support, live events, and stress and modifiers of adjustment to bereavement by older adults. *Psychology and Aging, 5*(3), 429-436.

Notermans, C. (2008). The emotional world of kinship: Children's experiences of fosterage in east Cameroon. *Childhood, 15*(3), 355-377.

Ntsimane, R. (2005). Memory boxes and Zulu culture. In P. Denis (Ed.), *Never too small to remember: Memory work and resilience in times of AIDS* (pp. 35-40). Pietermaritzburg: Cluster Publications.

Nyambedha, E. O., Wandibba, S., & Aagaard-Hansen, J. (2003). Changing patterns of orphan care due to the HIV epidemic in western Kenya. *Social Science & Medicine, 57*(2), 301-311.

Ogunmefun, C., Gilbert, L., & Schatz, E. (2011). Older female caregivers and HIV/AIDS related secondary stigma in rural South Africa. *Journal of Cross-Cultural Gerontology, 26*(1), 85-102.

O'Kane, C. (1998). Children and decision-making: Ethical considerations. In V. Johnson, E. Ivan-Smith, G. Gordon, P. Pridmore, & P. Scott (Eds.), *Stepping forward: Children and young people's participation in the developing process* (pp. 36-41). London: Intermediate Technology Publications.

O'Toole, M. (2003). *Miller-Keane Encyclopedia & Dictionary of Medicine, Nursing & Allied Health* (7th ed.). Philadelphia, PA: W.B. Saunders.

Palin, F. L, Armistead, L., Clayton, A., Ketchen, B., Lindner, G., Kokot-Louw, P., & Pauw, A. (2009). Disclosure of maternal HIV-infection in South Africa: Description and relationship to child functioning. *Aids Behavior, 13*(6), 1241-1252.

Parikh, A., Bachman DeSilva, M., Cakwe, M., Quilnlan, T., Simon, J. L., Skalicky, A., & Zhuwau, T. (2007). Exploring the Cinderalla myth: Intrahousehold differences in child wellbeing between orphans and non-orphans in Amajuba District, South Africa. *Aids, 21*(suppl 7), S95-S103.

Parish, S.M. (1997). Children. In T. Barfield (Ed.). *The dictionary of anthropology* (pp. 59-61). Oxford, Malden: Blackwell.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine, 57*(1), 13-24.

Parkes, C.M. (2010). Bereavement as a psychosocial transition: Processes of adaptation to change. *Journal of Social Issues, 44*(3), 53 – 65.

Parsons, R. (2010). Eating in mouthfuls while facing the door: Some notes on childhoods and their displacements in Eastern Zimbabwe. *Journal of Southern African Studies, 36*(2), 449-463.

Pelham, L. (2007). *The politics behind the non-contributory old age social pensions in Lesotho, Namibia and South Africa. Chronic Poverty Research Centre Working Paper 83.* Chronic Poverty Research Centre. Retrieved 2019, August 31 from http://www.chronicpoverty.org/uploads/publication_files/WP83_Pelham.pdf

Peltzer, K., & Ramlagan, S. (2011). Perceived stigma among patients receiving antiretroviral therapy: A prospective study in KwaZulu-Natal, South Africa. *AIDS Care, 23*(1), 60-68.

Pfefferbaum, B., North, C. S., Doughty, D. E., Pfefferbaum, R. L., Dumont, C. E., Pynoos, R. S., … Ndetei, D. (2006). Trauma, grief and depression in Nairobi children after the 1998 bombing of the American Embassy. *Death Studies, 30*(6), 561-577.

Philips, R., Benoit, C., Hallgrimsdottir, H., & Vallance, K. (2012). Courtesy stigma: A hidden health concern among front-line service providers to sex workers. *Sociology of Health & Illness, 34*(5), 681-696.

Posel, D., Kahn, K., & Walker, L. (2007). Living with death in a time of AIDS: A rural South African case study. *Scandinavian Journal of Public Health, 35*(Suppl 69), 138-146.

Poulsen, M. N., Miller, K. S., Lin, C., Fasula, A., Vandenhoudt, H., Wyckoff, S. C., … Forehand, R. (2010). Factors associated with parent-child communication about HIV/AIDS in the United States and Kenya: A cross-cultural comparison. *AIDS and Behavior, 14*(5), 1083–1094.

Pozzo, M., & Evers, S. J. T. M. (2016). 'Staying active' in confined living conditions: Participation assessments of young asylum seekers (aged 12-23) in the Netherlands. *Children's Geographies*, *14*(4), 468-481.

Prigerson, H.G., Maciejewski, P.K., Reynolds, C.F., 3rd, Bierhals, A.J., Newson, J.T., Fasiczka, A., … Miller, M. (1995). Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research, 59*(1-2), 65-79.

Punch, S. (2002). Research with children: The same or different from research with adults? *Childhood, 9*(3), 321-341.

Punch, S. (2002a). Interview strategies with young people: The 'secret box', stimulus material and task-based activities. *Children and Society*, *16*(1), 45-56.

Qiao, S., Li, X., & Stanton, B. (2011). Disclosure of parental HIV infection to children: A systematic review of global literature. *AIDS and Behavior, 17*(1), 369-389.

Quinn, N. (2005). Universals of childrearing. *Anthropological Theory*, *5*(4), 477-516.

Rapport, N., & Overing, J. (2000). Children. In N. Rapport, & J. Overing, *Social and Cultural Anthropology: The key concepts* (pp. 29-32). London and New York: Routledge.

Raveis, V.H., Siegel, K., & Karus, D. (1999). Children's psychological distress following the death of a parent. *Journal of Youth and Adolescence, 28*(2), 165-18.

Ribbens McCarty, J. (2007). 'They all look as if they're coping, but I'm not': The relational power/less of 'youth' in responding to bereavement. *Journal of Youth Studies, 10*(3), 285-303.

Richter, L. (2004). The Impact of HIV and AIDS on the Development of Children. In R. Pharaoh (Ed.), *A Generation at Risk? HIV and AIDS, Vulnerable Children and Security in Southern Africa*. Monograph No. 109 (pp. 9-31). Pretoria, South Africa: Institute for Security Studies.

Richter, A., & Müller, J. (2005). The forgotten children of Africa: Voicing HIV and Aids orphans' stories of bereavement: a narrative approach. *HTS Teologiese Studies, 61*(3), 999-1015.

Richter, L., Komárek, A., Desmond, C., Celentano, D., Morin, S., Sweat, M., … Coastes, T. (2014). Reported physical and sexual abuse in childhood and adult HIV risk behavior in three African countries: Findings from Project Accept (HPTN-043). *Aids and Behavior, 18*(2), 381-389.

Rolls, L. & Payne, S. (2007). Children and young people's experiences of UK bereavement services. *Mortality*, *12*(3), 281-303.

Rosenblatt, P.C. (1995). Ethics of qualitative interviewing with grieving families. *Death Studies, 19*(2), 139-155.

Rosenblatt, P. C. (1997). Grief in small-scale societies. In C. M. Parkes, P. Laungani, & B. Young (Eds.), *Death and bereavement across cultures* (pp. 27-51). London, New York: Routledge.

Rosenblatt, P. C. (2000). *Parents grief: Narratives of loss and relationship*. Philadelphia: Brunner/Mazel.

Rosenblatt, P.C. (2001). A social constructionist perspective on cultural differences in grief. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping and care* (pp. 285-300). Washington DC: Apa.

Rosenblatt, P.C. (2006). Grief: The social context of private feelings. In: M.S. Stroebe, W. Stroebe & R.O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (8th ed.) (pp. 102-111). Cambridge: Cambridge University Press.

Rosenblatt, P. C. (2013). Family grief in a cross-cultural perspective. *Family Science, 4*(1), 12-19.

Rosenblatt, P.C., & Nkosi, B.C. (2007). South African Zulu widows in a time of poverty and social change. *Death Studies, 31*(1), 67-85.

Rotheram-Borus, M.J., Weiss, R., Alber, S., & Lester, P. (2005). Adolescent adjustment before and after HIV-related parental death. *Journal of Consulting and Clinical Psychology, 73*(2), 221-228.

Rowling, L. (1999). Being in, being out, being with: Affect and the role of the qualitative researcher in loss and grief research. *Mortality: Promoting the interdisciplinary study of death and dying, 4*(2), 167-181.

Ruiz-Casares, M., Thombs, B. D., & Rousseau, C. (2009). The association of single and double orphanhood with symptoms of depression among children and adolescents in Namibia. *European Child & Adolescent Psychiatry, 18*(6), 369-376.

Rwemisisi, J., Wolff, B., Coutinho, A., Grosskurth, H., & Whitworth, J. (2008). 'What if they ask how I got it?': Dilemmas of disclosing parental HIV status and testing children for HIV in Uganda. *Health Policy Plan, 23*(1), 36-42.

Sagberg, S., & Røen, I. (2011) Social practices of encountering death: a discussion of spiritual health in grief and the significance of worldview. *International Journal of Children's Spirituality, 16*(4), 347-360.

Scelza, B. A., & Silk, J.B. (2014). Fosterage as a system of dispersed cooperative breeding: Evidence from the Himba. *Human Nature, 25*(4), 448-464.

Schrimshaw, E., & Siegel, K. (2002). HIV-infected mothers' disclosure to their uninfected children: Rates, reasons, and reactions. *Journal of Social and Personal Relationships, 19*(1), 19-43.

Scott, J. (2008). Children as respondents: The challenge for quantitative methods. In P. Christensen, & A. James (Eds.), *Research with children: Perspectives and practices* (2nd ed.) (pp. 87-108). London - New York: Routledge.

Shapiro, E. R. (2008). Whose recovery, of what? Relationships and environments promoting grief and growth. *Death Studies, 32*(1), 40-58.

Shapiro, D., Howell, K., & Kaplow, J. (2014). Associations among mother–child communication quality, childhood maladaptive grief, and depressive symptoms. *Death Studies*, *38*(3), 172–178.

Sherr, L., & Mueller, J. (2009). Where is the evidence base? Mental health issues surrounding bereavement and HIV in children. *Journal of Public Mental Health, 7*(4), 31-39.

Sherr, L., Varrall, R., Mueller, J., JLICA Workgroup 1 Members, Richter, L., Wakhweya, A., … Desmond, C. (2008). A systematic review on the meaning of the concept 'AIDS Orphan': Confusion over definitions and implications for care. *AIDS Care, 20*(5), 527-536.

Shetty, A.K., & Powell, G. (2003). Children orphaned by AIDS: A global perspective. *Seminars in Pediatric Infectious Diseases, 14*(1), 25-31.

Slaughter, V. (2005). Young children's understanding of death. *Australien Psychologist, 40*(3), 179-186.

Siegel, K., & Gorey, E. (1994). Childhood bereavement due to parental death from Acquired Immunodeficiency Syndrome. *Developmental and Behavioral Pediatrics, 15*(3), S66-S70.

Silverman, S. M., & Silverman, P. R. (1979). Parent-child communication in widowed families. *American Journal of Psychotherapy, 33*(3), 428-441.

Silverman, P. R., & Worden, J. W. (1992). Children's reactions in the early months after the death of parent. *American Journal of Orthopsychiatry,62*(1), 93-104.

Silverman, P.R. & Worden, J.W. (1993). Children's reactions to the death of a parent. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 300-316). Cambridge: Cambridge University Press.

Silverman, S.M., Weiner, A., & Elad, N. (1995). Parent-child communication in bereaved Israeli families. *Omega, 31*(4), 275-293.

Social Impact Assessment and Policy Analysis Centre (SIAPAC) (2002). *A situation analysis of orphan children in Namibia.* Prepared by the SIAPAC for the Ministry of Health and Social Services and UNICEF, Windhoek

Society for Research in Child Development (SRCD)(n.d.). *Ethical Standards in Research* (Updated March 2007). Retrieved 2019, August 6 from http://www.srcd.org/about-us/ethical-standards-research

Stevenson, M., Achille, M., Liben, S., Proulx, M., Humbert, N., Petti, A. …Cohen, R. (2017). Understanding how bereaved parents cope with their grief to inform the services provided to them. *Qualitative Health Research, 27*(5), 649-664.

Stith, S.M., Liu, T., Davies, C., Boykin, E. L., Alder, M. C., Harris, J. M., … Dees, J. E. M. E. G. (2009). Risk factors in child maltreatment: A meta-analytic review of the literature. *Aggression and Violent Behavior, 14*(1), 13-29.

Stokes, J. (2009). *Encyclopaedia of the Peoples of Africa and the Middle East*. New York: Infobase.

Straight, B. (2010). Death, grief and cross-world longing. *Reviews in Anthropology, 39*(2), 127-147.

Stroebe, M. (2003). Bereavement research: Methodological issues and ethical concerns. *Palliative Medicine, 17*(3), 235-240.

Stroebe, M., & Schut, H. (1998). Culture and grief. *Bereavement Care, 17*(1), 7-11.

Stroebe, M., Schut, H., & Boerner, K. (2010). Continuing bonds in adaptation to bereavement: Towards theoretical integration. *Clinical Psychology Review, 30*(2), 259-268.

Stroebe, M.S., W. Stroebe & R.O. Hansson (1993). Bereavement research and theory: An introduction to the Handbook. In M.S. Stroebe, W. Stroebe & R.O. Hansson (Eds)., *Handbook of bereavement: Theory, research and intervention (*pp.3-19). Cambridge: Cambridge University Press.

Stroebe, M.S., Hansson, R. O., & Stroebe, W. (1993). Contemporary themes and controversies in bereavement research. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 457-476). Cambridge: Cambridge University Press.

Stuber, J., Meyer, I., & Link, B. (2008). Editorial: Stigma, prejudice, discrimination and health. *Social Science & Medicine, 67*(3), 351-357.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine, 48*(10), 1449-1462.

Tersbøl, B. P. (2002). How to make sense of love relationships, Kwanuama culture and reproductive health. In V. Winterfelt, T. Fox, & P. Mufune (Eds.), *Namibia. Society. Sociology.* (pp. 347-359). Windhoek: University of Namibia Press.

Thomas, A. (2000). 'Poverty and the 'end of development'. In T. Allen & A. Thomas (Eds.), *Poverty and Development into the 21st century* (pp. 3-22). Oxford: Oxford University Press.

Thomas, B., Nyamathi, A., & Swaminathan, S. (2009). Impact of HIV/AIDS on mother in Southern India: A qualitative study. *AIDS and Behavior, 13*(5), 989-996.

Thomas, F. (2006). Stigma, fatigue and social breakdown: Exploring the impact of HIV/AIDS on patient and carer well-being in the Caprivi Region, Namibia. *Social Science & Medicine, 63*(12), 3174-3187.

Thomas, N. (2012). Love, rights and solidarity: Studying children's participation using Honneth's theory of recognition. *Childhood, 19*(4), 453-466.

Thomas, N., & O'Kane, C. (1998). The ethics of participatory research with children. *Children and Society, 12*(5), 336-348.

Thupayagale-Tshweneagage, G., & Benedict, S. (2011). The burden of secrecy among South African adolescents orphaned by HIV and AIDS. *Issues in Mental Health Nursing, 32*(6), 355-358.

Thurman, T.R., Taylor, T.M., Luckett, B., Spyrelis, A. & Nice, J. (2018). Complicated grief and caregiving correlated among bereaved adolescent girls in South Africa. *Journal of Adolescence, 62*, 82-86.

Tisdall, E.K.M. & Punch, S. (2012). Not so 'new'? Looking critically at childhood studies. *Children's Geographies, 10*(3), 249-264.

Tönjes, H. (1996) [1911]. *Ovamboland. Country. People. Mission. With particular reference to the largest tribe, the Kwanyama* (Originally published in 1911 in German.) Windhoek: Namibia Scientific Society.

Total Control of the Epidemic (TCE) (n.d.). Retrieved 2019, August 6 from http://www.tce-aids.org/tce-globally/namibia

Tremblay, G. C., & Israel, A. C. (1998). Children's adjustment to parental death. *Clinical Psychology: Science and Practice*, *5*(4), 424-438.

Turan, J.M., Bukusi, E.A., Onono, M.,Holzemer, W.L., Miller, S.,& Cohen, C.R. (2011). HIV/AIDS stigma and refusal of HIV testing among pregnant women in rural Kenya: Results from the MAMAS study. *AIDS and Behavior, 15*(6), 1111-1120.

Turan, J. M., Nyblade, L., & Monfiston, P. (2012). *Stigma and Discrimination: Key Barriers to Achieving Global Goals for Maternal Health and the Elimination of New Child HIV Infections. Working Paper No. 4.* The Health Policy Project. Retrieved from 2019, August 31 from https://www.healthpolicyproject.com/pubs/92_WorkingPaperStigmaPMTCTJuly.pdf

United Nations (UN) (2000). *Enhancing Social Protection and Reducing Vulnerability in a Globalizing World. Report of the Secretary General to the 39th Session E/CN.5/2001/2/.* New York: United Nations Economic and Social Council.

United Nations Children's Fund (UNICEF) (n.d.). *Orphans.* Retrieved 2019, March 29, from https://www.unicef.org/media/media_45279.html.

United Nations Children's Fund (UNICEF) (n.d.a). Retrieved 2019, August 6 from https://www.unicef.org/namibia/protection_13675.html

United Nations Children's Fund (UNICEF) (1995). *Children in Namibia. Reaching towards the rights of every child.* Windhoek, Namibia: UNICEF.

United Nations Children's Fund (UNICEF) (2004). *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS.* New York: UNICEF. Retrieved 2019, August 31 from http://www.unicef.org/aids/files/Framework_English.pdf

United Nations Children's Fund (UNICEF) (2011). *Children and HIV & AIDS in Namibia.* Windhoek: UNICEF, UNAIDS.

United Nations Children's Fund (UNICEF) (2015). Passing of child care and protection bill, is a major milestone for the country, UNICEF says. Retrieved from 2019, August 31 from https://www.unicef.org/esaro/5440_nam2015_child-care-bill.html

United Nations Children's Fund (UNICEF) (2015a). *Child Grants Fact Sheet.* Retrieved 2019, August 31 from https://www.unicef.org/namibia/Child_grants_fact_sheet_print.pdf

United Nations Children's Fund (UNICEF) (2016). *Prevention of Violence against Children and Women.* Retrieved 2019, August 31 from https://www.unicef.org/namibia/Violence_fact_sheet_print.pdf

United Nations Children's Fund (UNICEF) and Republic of Namibia. (2013). *Towards a Namibia Fit for Children. Situational Analysis on the Status of Children's and Adolescents' Rights, 2010-2013.* Windhoek: UNICEF Namibia/Republic of Namibia.

United Nations Development Programme (UNDP) (1994). *Human Development Report 1994.* New York - Oxford: Oxford University Press. Retrieved 2019, August 8 from http://hdr.undp.org/sites/default/files/reports/255/hdr_1994_en_complete_nostats.pdf

United States Bureau of Democracy Human Right and Labor (2007). *International Religious Freedom Report 2007: Namibia*. United States Bureau of Democracy, Human Rights and Labor (September 14, 2007). Retrieved 2019, August 6 from https://2009-2017.state.gov/j/drl/rls/irf/2007/90112.htm

Uprichard, E. (2010). Questioning research with children: Discrepancy between theory and practice? *Children & Society, 24*, 3-13.

U.S. Agency for International Development (USAIDS) Namibia (2009). *Measure Evaluation. HIV/AIDS in Namibia: Behavioural and contextual factors driving the epidemic.* Windhoek: Macro International Inc.

Valentine, C. (2006). Academic constructions of bereavement. *Mortality, 11*(1), 57-78.

Valentine, C. (2008). *Bereavement narratives: Contuining bonds in the 21st century.* London and New York: Routlegde

Van der Brug, M. (2007). *World and experiences of AIDS orphans in North-Central Namibia*. Leiden: African Studies Centre.

Van der Brug, M. (2011). Using a "Kids Club Method" to understand experiences of children orphaned by AIDS in north-central Namibia. In S. J.T.M. Evers, C. Notermans, & E. Van Ommering (Eds.), *Not just a victim: The child as catalyst and witness of contemporary Africa* (pp. 43-67). Leiden - Boston: Brill.

Van der Brug, M. (2012). Strategies to bring about change: a longitudinal study on challenges and coping strategies of orphans and vulnerable children and adolescents in Namibia. *African Journal of AIDS Research,11*(3), 273-282.

Van der Heijden, I., & Swartz, S. (2010). Bereavement, silence and culture within a peer-led HIV/AIDS prevention strategy for vulnerable children in South Africa. *African Journal of AIDS Research, 9*(1), 41-50.

Van Dijk, D. (2008). *'Beyond their age': Coping of children and young people in child-headed households in South Africa.* Leiden: African Studies Centre.

Van Velsen, J. (1964). *The politics of kinship: A study in the social manipulation among the lakeside Tonga of Malawi.* Manchester: Manchester University Press.

Vaz, L.M.E, Eng, E., Maman, S., Tshikandu, T. & Behets, F. (2010). Telling children they have HIV: Lessons learned from findings of a qualitative study in Sub-Saharan Africa. *AIDS patient care and STDs, 24*(4), 247-256.

Veale, A. (2005). Creative methodologies in participatory research with children. In S. Greene, & D. Hogan (Eds.), *Researching Children's Experience: Methods and Approaches* (pp. 253-272). London - Thousand Oaks - New Delhi: Sage publications.

Vermeulen, T., & Greeff, A. P. (2015). Family resilience resources in coping with child sexual abuse in South Africa. *Journal of Child Sexual Abuse, 24,* 555-571.

Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality, 1*(1), 7-25.

Walter, T. (2010). Grief and culture. *Bereavement Care, 29*(2), 5-9.

Wamoyi, J., Fenwick, A., Urassa, M., Zabas, B., & Stones, W. (2010). Parent-child communication about sexual and reproductive health in rural Tanzania: Implications for young people's sexual health interventions. *Reproductive Health, 7(*6), 1-18.

Weiss, B. (1997). Forgetting your dead: Alienable and inalienable objects in Northwest Tanzania. *Anthropological Quarterly, 70*(4), 164-170.

Wellenkamp, J. C. (1988). Notions of grief and catharsis among the Toraja. *American Ethnologist, 15*(3), 486-500.

Westcott, H. L., & Littleton, K. S. (2005). Exploring meaning in interviews with children. In S. Greene, & D. Hogan (Eds.), *Researching children's experience: Methods and approaches* (pp. 141-157). London - Thousand Oaks - New Delhi: Sage publications.

White, G. (1997). Emotions. In T. Barfield (Ed.), *The dictionary of anthropology* (pp. 148-149). Oxford - Malden: Blackwell.

White, A., Bushin, N., Carpena-Méndez, F., & NíLaoire, C. (2010). Using visual methodologies to explore contemporary Irish childhoods. *Qualitative Research, 10*(2), 1-16.

Wieringa, S.E. (2002). *Gender, transition, sexual diversity and AIDS in post-colonial Southern Africa: Some suggestions for research.* In D. LeBeau, & R.J. Gordon (Eds.), *Challenges for anthropology in the 'African renaissance', a Southern African contribution* (pp. 124-137). Windhoek, Namibia: University of Namibia Press.

Wikan, U. (1988). Bereavement and loss in two Muslim communities: Egypt and Bali compared. *Social Science & Medicine, 27*(5), 451-460.

Winston, C. A. (2006). African American grandmothers parenting AIDS orphans: Grieving and coping. *Qualitative Social Work, 5*(1), 33-43.

Witter, S., & Were, B. (2004). Breaking the silence: Using memory books as a counselling and succession-planning tool with AIDS-affected households in Uganda. *African Journal of AIDS Research, 3*(2), 139-143.

Wood, K., Chase, E., & Aggleton, P. (2006). 'Telling the truth is the best thing': Teenage orphans' experiences of parental AIDS-related illness and bereavement in Zimbabwe. *Social Science & Medicine, 63*(7), 1923-1933.

Worden, J.W. (1996) Tasks and mediators of mourning: A guideline for the mental health practitioner. *In Session Psychotherapy in Practice, 2,* 73-80.

World Bank (2013). "World Development Indicators 2013." Washington, D.C.: World Bank. Retrieved 2018, August 3 from http://data.worldbank.org/data-catalog/world-development-indicators.

Wright, C., & Coyle. A. (1996). AIDS-related bereavement among gay men: Implications for care. *Mortality, 1,* 267-282.

World Health Organisation (WHO) (n.d.) *Adult mortality rate, 2000-2016.* Retrieved August 5, 2019, August 5, from https://www.who.int/gho/mortality_burden_disease/mortality_adult/situation_trends_text/en/

Young, B., & Papadatou, D. (1997). Childhood death and bereavement across cultures. In C. M. Parkes, P. Laungani, & B. Young (Eds.), *Death and Bereavement Across Cultures* (pp. 191-205). London - New York: Routledge.

Zhao, G., Li, X., Fang, X., Zhao, J., Yang, H., & Stanton, B. (2007). Care arrangements, grief and psychosocial problems among children orphaned by AIDS in China. *AIDS Care, 19*(9),1075-1082.